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# Report of the Elliot Lake Commission of Inquiry

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## Part Two:

The Emergency Response  
and Inquiry Process

**The Honourable Paul R. Bélanger**  
*Commissioner*







# Report of the Elliot Lake Commission of Inquiry

## **Part Two:**

The Emergency Response  
and Inquiry Process

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*Commissioner*



The Report consists of three volumes:

1. The Events Leading to the Collapse of the Algo Centre Mall;
2. The Emergency Response and Inquiry Process; and
3. Executive Summary.

Ontario Ministry of the Attorney General

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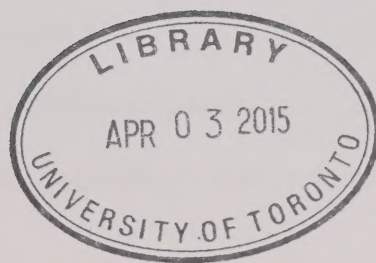
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■ This volume is dedicated to all first responders –  
■ those who put their life and health in harm's way  
■ to help others. They are our heroes.  
■





•  
• *True heroism is remarkably sober, very undramatic. It is*  
•  
• *not the urge to surpass all others at whatever cost, but the*  
•  
• *urge to serve others at whatever cost.*  
•  
•  
•

– Arthur Ashe





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## Introduction

*Before, you are wise; after, you are wise. In between you are otherwise.*

David Zindell, *The Broken God*



*It is easy to be wise after the event.*

Arthur Conan Doyle, *The Complete Sherlock Holmes*



This second volume of the Report examines the emergency response in the aftermath of the Algo Mall collapse. Unlike Part One, which reviewed a span of more than 30 years, these chapters set out a story of less than a week in duration. Compared to the behaviour of many of the players whose three-decade-long involvement in the Mall's well-being may be questioned and criticized, the emergency response cannot be faulted for lack of praiseworthy intentions, engagement, determination, and, not infrequently, bravery and courage.

During this response, a congruence of errors – some minor, some more important – led to a rescue effort that was no model of perfection. As a result, questions will long persist about the possibility that Lucie Aylwin could have been rescued. As I pointed out elsewhere in this Report, we learn best through experience. A critical analysis of that experience is crucial to identify error or to confirm success. The lessons learned can then be transmitted to others – to improve future responses.

In this part of the Report, I will attempt a detailed narrative of the events that followed the collapse on June 23, 2012. Inevitably, given the varying quality of observation in times of stress, there will be different interpretations of discrete events. That is the nature of human memory, particularly when it is unaided by contemporaneous recording and prompt, careful debriefing.

Doloris Perizzolo's death was unquestionably and mercifully quick. But the extent to which miscues, miscommunications, and mistakes prevented the rescue of Lucie Aylwin is a difficult question. Some medical evidence supports the proposition that death came quickly. However, living for a period of time was not inconsistent with any of the medical indicia discussed by one medical witness. Tantalizing signs may lead one to conclude that it is probable (though by no means certain) that she lived for some time after the initial collapse and might have been found alive had the rescue effort been executed more rapidly and effectively. By 5 a.m. on June 25, however, it is probable (but again, not conclusively certain) that she had died. We will never confidently know the answer to these troubling concerns.



The hearings for this part of the Inquiry lasted 36 days, and I heard 52 witnesses. Many of those witnesses, family members and loved ones in particular, recounted being desperate for information and decried the quality and manner in which it was communicated to them.

I heard from first responders who worked to exhaustion, yet resisted and resented being ordered to stop. I heard from community and first-response leaders who were well-meaning, but often appeared confused about their roles and responsibilities.

I heard from the province's premier, Dalton McGuinty, whose concern and support throughout the ordeal was genuine and constant. He gave hope and renewed determination when the rescue effort had ebbed to its lowest point. I also heard from the region's MPP (Algoma-Manitoulin), Michael Mantha, whose presence, assistance, and moral support to the community was unflagging and tireless and who represented the best of what is expected of our elected representatives.

My analysis of the facts underpinning this narrative follows, along with my recommendations to improve emergency responses. I also describe the process of this Inquiry and make suggestions for future such commissions. Improvement is achieved gradually and incrementally and builds on the shoulders of others. Perfection is an impossibly elusive goal – one that is virtually never achieved. As Vince Lombardi is quoted as saying, "Perfection is not attainable, but if we chase perfection we can catch excellence."

I embark on that analysis with diffidence and some significant reservation, because I am aware of this Commission's lack of expertise in emergency rescue operations. The training and practical experience of many of the first responders was decades long. My learning period, as well as that of Commission counsel, has been brief and purely theoretical.

I am also conscious, as I previously commented, of the perils of judging events in hindsight. Choosing the right path through the thicket is easy when you can look down on it from a high vantage point, but not when you are enmeshed in it on perilous ground. Although hindsight is a dangerous tool in assessing past conduct, it is, however, essential in crafting recommendations. Many witnesses, experts in their own right, commented in their testimony on what they and others should have done differently. Their views are important and valuable, and, in crafting my recommendations, I gave a lot of weight to their opinions.

Unfortunately, the rescue effort that was mounted after the collapse did not save any lives. The measure of a response's effectiveness cannot simply be gauged by whether lives were saved as a result of it. That measure is far too simplistic. An inept rescue may save lives by pure luck or cause the further loss of life; by contrast, circumstances may defeat the best-executed plans.

One constant, however, stands out above all the others: an effective and efficient first-response system is essential to the health, safety, and security of Ontario's citizens. With the integration of Ontario's first-response organizations with those of other provinces, this system is now also essential for all Canadians. Any diminution in the financial contributions of governments – municipal, provincial, or federal – is unwarranted and dangerous. Quite the opposite: those contributions should be enhanced.

The evidence I heard in the second phase of the Inquiry provided me with a view into the world of emergency management and response. This world, I have come to learn, is heavily populated by totally committed, selfless, and courageous men and women. That said, it still remains that few human endeavours cannot be improved upon. Any criticism I make about any aspect of the response to the Algo Mall collapse should not be interpreted as a lessening of my esteem and admiration for our first responders.



Stated in their simplest terms, my principal conclusions for this part of the Inquiry are as follows:

- Doloris Perizzolo's death was nearly instantaneous after the collapse, but it is probable (though by no means certain) that Lucie Aylwin survived under the rubble for a period of up to 39 hours. It is unlikely that she survived beyond 5 a.m. on June 25. There exists a possibility she might have been rescued, but we will never know for sure.
- Local authorities acted promptly and appropriately in the immediate aftermath of the collapse. They assisted in the evacuation of the Mall, helped the injured, and secured the site by shutting off utilities and establishing site control. Provincial authorities were rapidly informed, and assistance was summoned after the declaration of a municipal emergency.
- HUSAR/TF3 could have deployed more rapidly. UCRT's deployment speed was exceptional.
- Both HUSAR/TF3 and UCRT deployment numbers were not optimal, particularly at the command level.
- The lack of an incident action plan was detrimental to the rescue effort.
- The Incident Management System was improperly applied: no one understood or respected its mandated command structure.
- The relationship between HUSAR/TF3 and UCRT was occasionally problematic.
- There was a failure to resort to crane / rigging operations early and consistently – they were relegated to a solution of last resort.
- Record-keeping and note-taking were deficient.
- Communications among responders, with victims' families, and with the media and the general public were poor.
- Although it was proper to remove the rescuers from the building because of the dangerous state of the rubble pile, the rescue was called off, instead of being paused while alternatives were considered.
- The services offered by Ontario Mine Rescue should not have been ignored.
- The role of Ministry of Labour officials was widely misunderstood.
- After-action debriefings and many after-action reports were either non-existent or poorly done.
- Provincial legislation, including the *Coroners Act*, does not allow an official to demolish a building to retrieve a body.
- The premier of Ontario, his office, and other provincial authorities acted with leadership, genuine compassion, and assistance when hope seemed lost.
- Ontario's urban search and rescue system needs a careful re-examination to provide better overall coverage and quality of service.

One final comment: I was informed during the hearings that Fire Chief Paul Officer's nomination of certain of his Elliot Lake firefighters for the Ontario Medal for Firefighter Bravery Award have been put on hold until this Commission has completed its work. These awards should wait no longer. They are richly deserved.





# Background of Responders and Emergency Management

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To understand the response to the collapse of the Algo Mall, it is necessary to first review the way the province, the municipalities, and other responders are organized to deal with emergencies of this type. Accordingly, I will provide background information in this chapter on

- emergency management in Ontario;
- the Incident Management System;
- organizations that participated directly in the rescue; and
- organizations that provided support and advice.

The description of the emergency management structure in Ontario that follows reflects the one in place at the time of the Mall's collapse. Although there have been some administrative changes since then, it is my understanding that the framework remains essentially the same.

## Emergency management in Ontario

The primary provincial legislation dealing with emergency management is the *Emergency Management and Civil Protection Act* (EMCPA). It reflects the five pillars of emergency management:

- mitigation
- prevention
- preparation
- response
- recovery<sup>1</sup>

The Act defines “emergency” as “a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.”<sup>2</sup>

## Graduated problem solving and emergency response

**Where an emergency escalates beyond the capacities of the individual or family, the expectation is that the local community or municipality will take over. Communities assist as a matter of routine through emergency responders such as police, fire, and emergency medical services.**

The first response is almost always local: it begins with the individual or the family and evolves from there. The province's emergency response regime is designed to reflect this process. The Ontario government's Provincial Emergency Response Plan expects individuals and families to be able to respond to an emergency and be self-sufficient for the first 72 hours.<sup>3</sup> This approach is described as “graduated problem-solving.”<sup>4</sup> It is “bottom up” and meant to keep emergency response as localized as possible while ensuring that all the necessary resources are available in a timely fashion.

Where an emergency escalates beyond the capacities of the individual or family, the expectation is that the local community or municipality will take over. Communities assist as a matter of routine through emergency responders such as police, fire, and emergency medical services.<sup>5</sup>



Where the emergency in question overwhelms the capacities of the local municipality or community and its first responders, the next step is to seek mutual aid or assistance from neighbouring services, municipalities, and communities or from the local county or region. Mutual aid programs are unique to fire services and are required under the *Fire Protection and Prevention Act*.<sup>6</sup> Municipalities can also form agreements with neighbouring communities to provide assistance to each other in times of need for matters that are not related to fires. These agreements are called “mutual assistance.”<sup>7</sup>

Where the mutual aid or assistance system will not suffice, the local community can look to the Ontario government for further support. The Province of Ontario has emergency resources and expertise which may be used to deal with emergency response needs that are beyond the capabilities of local communities.<sup>8</sup> Indeed, the local community can ask for provincial assistance at any time, even where the mutual aid or mutual assistance systems are sufficient.<sup>9</sup>

Finally, and depending on the nature and severity of the incident in question, the province may require the assistance of the federal government or even international assistance. The nature of the emergency may also be such that jurisdiction falls automatically to the federal government.<sup>10</sup>

The provision of assistance from one level of government to another may require a declaration of emergency, unless normal powers and procedures will suffice. A declaration of emergency, in keeping with the graduated approach, should be at the lowest level of jurisdiction. As such, it should seldom be necessary to declare a provincial or federal emergency, even though resources from these jurisdictions will frequently be provided in support of an emergency declared by a municipality or a First Nation.<sup>11</sup>

**The Province of Ontario has emergency resources and expertise which may be used to deal with emergency response needs that are beyond the capabilities of local communities.**

## The role of the municipality

In accordance with the graduated problem-solving model, emergency response in Ontario is to be managed at the lowest level possible – at the community or municipality level. As such, Ontario municipalities are subject to a series of legislated responsibilities related to emergency response, chiefly pursuant to the *Emergency Management and Civil Protection Act*. The Act also sets out powers that may be exercised by the municipality and the province during an actual emergency, but without expressly defining the relationship between the province and the municipalities.<sup>12</sup>

All municipalities must have in place the following structure for emergency response. It includes the creation of community emergency management programs, emergency plans, control groups, emergency operation centres, and mutual aid arrangements.

## The municipal emergency management program

Every municipality in Ontario is required by law to develop and implement an emergency management program and to pass a by-law specifically adopting the program. It must include an emergency response plan, training programs, and exercise sessions for municipal employees and others as well as the procedures to be followed in emergency response and recovery activities. It must also provide for public education on the risks to public safety and on how the public can best be prepared for emergencies.<sup>13</sup> The training programs and exercises for municipal employees and others allow for the inclusion of non-governmental organizations that are expected to play a role in the emergency response plan – for example, the Salvation Army or the Red Cross.<sup>14</sup>

Dan Hefkey holds the position of commissioner for community safety, as he did when he appeared at the Inquiry. The fire marshal and the chief of Emergency Management Ontario both report directly to him. He explained that the *Emergency Management and Civil Protection Act* does not contain any provision dealing with non-compliance with the Act.<sup>15</sup> Although the Act requires municipalities to have an emergency management program that includes an emergency plan, there is no statutory penalty for those that do not comply. He testified, however, that there is almost complete compliance. At any time, on average, only four to eight municipalities in the province are deficient in some aspect of the requirements.<sup>16</sup>

Municipalities must conduct annual reviews of their emergency management programs and make recommendations to the local council about any revisions that are required.<sup>17</sup> The emergency management program must also assess various hazards and risks to public safety in the community which could give rise to emergencies and, in addition, identify facilities and infrastructure that are at risk of being affected by emergencies and for which the municipality is responsible.<sup>18</sup>

This process of hazard identification and risk assessment is expected to shape the plan. It identifies what the hazards are within the municipality and makes a judgment on the likelihood of an event happening as well as its consequences in terms of lives and property damage. Emergency Management Ontario, a branch of the Ministry of Community Safety and Correctional Services which is responsible for developing, promoting, and maintaining emergency programs, expects that each municipality will regularly revisit this assessment, simply because changes in circumstances require changes to emergency plans. Municipalities are not required to provide Emergency Management Ontario with a copy of their hazard identification and risk assessment.<sup>19</sup>

The emergency response plan sets out the procedures on how each particular municipality will respond to an emergency.<sup>20</sup> In addition, it lays out the responsibilities of municipal employees in carrying out the plan.\*

## Municipal emergency control groups

Municipalities are also required by regulation to have in place a municipal emergency control group – to direct the municipality's response in an emergency, including the implementation of the emergency response plan.<sup>21</sup> This group is more commonly referred to as the Community Control Group (CCG).<sup>22</sup>

Mr. Hefkey explained that the role of the CCG is to act in support of those who are actually dealing with the emergency. The group does not direct the responders – its concern is generally broader than the emergency incident itself and includes the effects and consequences of the emergency on the community.<sup>23</sup> The group must be composed of officials or employees of the municipality appointed by the municipal council, and it may include members of the City Council itself. All members of the group must complete annual training as required by the chief of Emergency Management Ontario.<sup>24</sup>

According to Mr. Hefkey, a CCG would typically include the mayor, deputy mayor, chief administrative officer, and the heads of the municipal departments such as public works, police, fire, emergency management services, public health, and social services.<sup>25</sup> When an emergency occurs, the municipality's emergency control group will usually convene to activate the emergency plan and, using that plan, access local resources to support emergency operations.<sup>26</sup>

• • • • •

\* *Emergency Management and Civil Protection Act*, O Reg 380/04, s 15.

Further instruction on minimum standards for municipal (and provincial) emergency management programs is found in Ontario Regulation 380/04, created to support the requirements in the *Emergency Management and Civil Protection Act*.



An incident commander may be appointed by the CCG to manage operations at the site of the emergency event. This commander is usually a senior officer from one of the local emergency services.<sup>27</sup> That said, an incident command structure will likely already have been in place at the onset of the emergency response, set up by the emergency first responders even before the declaration of emergency by the community.

### **Municipal emergency management program coordinator and committee**

The municipality must also designate an employee of the municipality or a member of the city council as its emergency management program coordinator. In addition, it must have in place an Emergency Management Program Committee (EMPC).<sup>28</sup>

The emergency management program coordinator manages the development and implementation of the municipality's emergency management program within the municipality and, to the extent possible, coordinates it with that of other municipalities, ministries of the Ontario government, and organizations outside government that are involved in emergency management.<sup>29</sup> The EMPC advises the municipal council on the development and implementation of the municipality's emergency management program. It also conducts an annual review of the program and makes recommendations to council for its revisions resulting from an updated hazard identification and risk assessment.<sup>30</sup>

### **Declaration of an emergency by the municipality**

Section 4 of the *Emergency Management and Civil Protection Act* provides that the head of the council in a municipality may declare that an emergency exists in either the whole or a part of the municipality. The council head will then take such action and make such orders as he or she considers necessary, and which are not contrary to law, to implement the municipality's emergency plan and to protect both the property and the health, safety, and welfare of the residents in the emergency area.<sup>31</sup> The declaration can be made whenever the head of council considers that an emergency exists. There is no condition precedent, or particular event, that must occur before the exercise of this power.<sup>32</sup> Of course, municipalities can (and do) take steps to respond to an emergency without making a formal declaration.<sup>33</sup>

**If a municipality declares an emergency, it must notify the province. On average, every year some 23 municipal emergency declarations are made in Ontario.**

If a municipality declares an emergency, it must notify the province.<sup>34</sup> On average, every year some 23 municipal emergency declarations are made in Ontario. However, no provincial emergency has been declared since the Act came into force in 2006.<sup>35</sup>

### **Community emergency operations centres**

During an emergency, municipalities are required to have a community Emergency Operations Centre (EOC) in place, operating under the direction of the municipal emergency control group.<sup>36</sup> From there the group manages the emergency. When an emergency situation arises, local municipalities are expected to follow their emergency plans and, where necessary, activate their EOC in order to coordinate local emergency response efforts.<sup>37</sup>

The municipality must appoint an emergency information officer to act as its primary media and public contact during an emergency.<sup>38</sup> That does not mean, however, that the emergency information officer has to be the spokesperson for the municipal emergency control group. It is expected that the designation of a spokesperson will be addressed within the emergency response plan.<sup>39</sup>

The municipality should have appropriate technological and telecommunications systems in place to ensure effective communication in an emergency. It must also have a procedure to inform the Provincial Emergency Operations Centre (PEOC) of an emergency and of possible requirements for assistance.<sup>40</sup>

### Mutual aid system and municipal capacity expectations

Within the gradual problem-solving approach, a municipality can rely on provincial mutual aid systems for fire departments when an emergency exceeds its capacity. The mutual aid system is established under the authority of the *Fire Protection and Prevention Act, 1997*, and administered by the Office of the Fire Marshal.

Fire coordinators, appointed by the Office of the Fire Marshal, are responsible for establishing and maintaining a mutual aid plan through which the various fire departments serving a designated area agree to assist each other in the event of an emergency.<sup>41</sup> Fire coordinators submit these mutual aid plans to the fire marshal for review and approval, and the Ministry of Community Safety and Correctional Services maintains a repository of all Ontario mutual aid plans for use in emergency situations.<sup>42</sup>

*The Fire Protection and Prevention Act, 1997, requires that municipalities provide fire protection services to their communities as necessary and in accordance with their needs and circumstances. Municipalities are not required to possess more extensive capacities such as urban search and rescue teams.*

The mutual aid can take the form of providing personnel and/or equipment to deal with the emergency. It also includes the provision of personnel from the neighbouring fire service to tend to the ongoing needs for fire protection services in the host community while the host fire service deals with the emergency.<sup>43</sup>

The *Fire Protection and Prevention Act, 1997*, requires that municipalities provide fire protection services to their communities as necessary and in accordance with their needs and circumstances. Municipalities are not required to possess more extensive capacities such as urban search and rescue teams.<sup>44</sup>

### Volunteers

Ontario's emergency response plan briefly addresses the role of volunteers and supporting organizations in an emergency response. Municipalities may require personnel, services, equipment, and/or material from non-profit or voluntary organizations and should include these types of considerations in their emergency response planning processes.<sup>45</sup>

The Provincial Emergency Response Plan makes the following cautionary comment about the use of volunteers during an emergency:

Municipalities and provincial ministries should carefully consider their need for, and the capabilities of, unaffiliated volunteer assistance during an emergency and systematically register all those who participate in the emergency response.<sup>46</sup>



## The role of the province

Where the municipal and local structure is insufficient to deal with an emergency, the municipality can look to the province for further resources and assistance.

The *Emergency Management and Civil Protection Act* contains organizational structures, roles, and responsibilities for all ministries that are analogous to those required of municipalities. For example, ministries must have a ministry emergency management coordinator and a ministry action group. The group's role and responsibilities are the same as those of a municipality's emergency control group.<sup>47</sup>

### Premier of Ontario

The *Emergency Management and Civil Protection Act* provides that the premier of Ontario may, if in his or her opinion the urgency of the situation requires that an order be made immediately, declare that an emergency exists throughout Ontario or in any part thereof.<sup>48</sup> If the emergency area or any part of it is within the jurisdiction of a municipality, the premier may, if deemed necessary, direct and control the administration, facilities, and equipment of the municipality in the emergency area<sup>49</sup> and may direct other municipalities to render assistance.<sup>50</sup>

The premier and the lieutenant governor in council may provide overall direction to the management of an emergency response when a provincial emergency has been declared, but not where the province has merely provided provincial resources or assistance to a municipality.<sup>51</sup>

### Lieutenant governor in council

Powers to declare an emergency are also conferred on the lieutenant governor in council. While the premier may declare a provincial emergency only if the urgency of the situation requires that such a declaration be made immediately, the lieutenant governor in council may do so if the resources normally available to the government are considered insufficient to respond adequately to the crisis.<sup>52</sup>

### Ministry of Community Safety and Correctional Services

The key ministry within the Government of Ontario for emergency response is the Ministry of Community Safety and Correctional Services. It houses important players in the emergency response field, including Emergency Management Ontario and the Office of the Fire Marshal. In August 2013, these two divisions were merged to form the Office of the Fire Marshal and Emergency Management. According to a government press release, "[t]his new, integrated organization will strengthen the co-ordination and delivery of community safety programs, without impacting front-line services."<sup>53</sup> Figure 2.2.1 sets out an organizational chart for the Community Safety side of the ministry as it existed on June 1, 2012.

If several ministries require a coordinated effort, the Ministry of Community Safety and Correctional Services will coordinate the joint response, normally through the Provincial Emergency Operations Centre (PEOC) described below. In addition, the ministry has the primary responsibility for managing the consequences of any structural collapse of buildings in Ontario.<sup>54</sup>

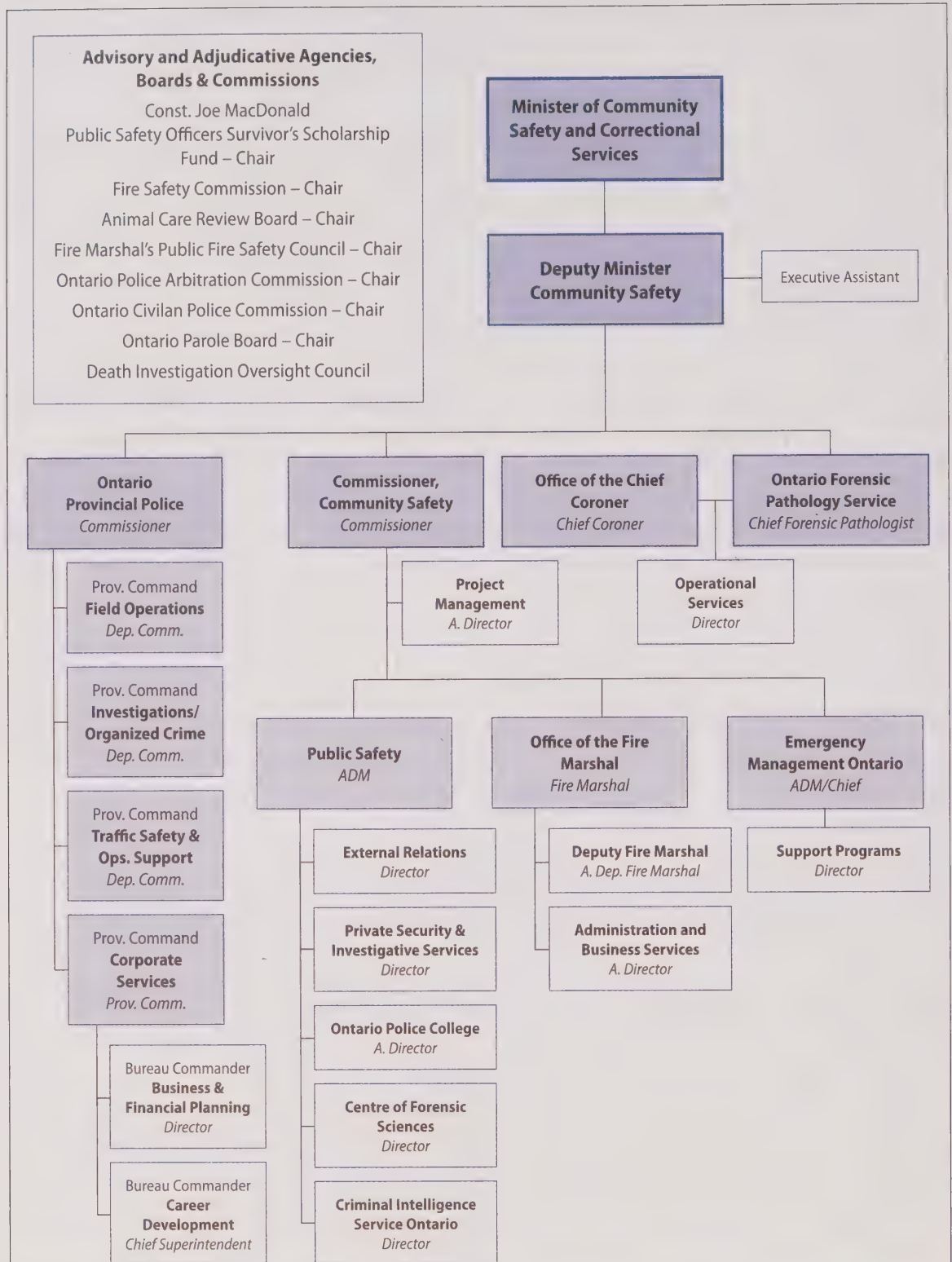


Figure 2.2.1 Organizational chart of the community safety side of Ministry of Community Safety and Correctional Services

Source Exhibit 7886



## Provincial Emergency Response Plan

The Ontario government is responsible for protecting public health and safety, property, and the environment within its borders. It has primary responsibility for managing the consequences of an emergency, such as a building's structural collapse or a chemical spill, once the community or the municipality has exceeded its resources, and for implementing mutual aid agreements. The Provincial Emergency Response Plan, developed pursuant to the *Emergency Management and Civil Protection Act*, is used to coordinate the overall provincial emergency response. It outlines how Emergency Management Ontario and the ministries respond to widespread or large-scale emergencies.<sup>55</sup>

The stated purpose of the Provincial Emergency Response Plan is to "establish a framework for a systematic, coordinated and effective emergency response by the Province of Ontario to safeguard the health, safety, welfare and property of its citizens, as well as to protect the environment and economy of the area affected by an emergency, excluding nuclear emergencies."<sup>56</sup> The Act requires the lieutenant governor in council to formulate a distinct emergency plan respecting emergencies arising in connection with nuclear facilities.<sup>57</sup>

### ***The Provincial Emergency Response Plan for Building Structural Collapse 2010***

All ministries of the provincial government are required to develop an emergency management program that includes an emergency plan. All ministers must develop an emergency plan for any emergency that affects the continuity of operations and services in their respective ministries. In addition, 13 ministers have been given the responsibility to develop emergency plans with respect to specific types of emergencies set out in Order in Council 1157-2009. These plans, developed by the ministries, fit within the overall Provincial Emergency Response Plan.<sup>58</sup> The Ministry of Community Safety and Correctional Services was given responsibility to develop the emergency response plan for the structural collapse of buildings.<sup>59</sup>

The *Provincial Emergency Response Plan for Building Structural Collapse 2010* recognizes that the primary responsibility for managing an emergency resulting from a building's structural collapse rests with the community and with local resources. The plan addresses how the province is intended to respond to such an emergency. It does not require the declaration of a provincial emergency to become operational. In fact, it does not specifically require the declaration of a municipal emergency. Since the community has responsibility for managing the emergency, the province has a supporting role by providing assistance. This assistance may take the form of simply providing advice, but it may also expand to the provision of personnel, equipment, and other resources to assist the community in dealing with the cause of the emergency.<sup>60</sup>

The province, through the Office of the Fire Marshal, has access to a number of specialized teams that can assist in the response to a building collapse – urban search and rescue teams as well as chemical, biological, radiological, nuclear, and explosive teams. Nearly all these teams are operated by municipalities. The province has entered into a memorandum of understanding with all the municipalities which allows it to deploy these teams under specified circumstances.<sup>61</sup> When provincial resources are sent to support a local municipality, they come under the operational control of the local incident commander in accordance with the provincial Incident Management System (IMS) doctrine described later.<sup>62</sup>

In the event of a building's structural collapse, the province has access to two urban search and rescue teams. The first, known as Canada Task Force 3 (TF3), or Toronto HUSAR, is a heavy-level urban search and rescue team operated by the City of Toronto.<sup>63</sup> The Ontario Provincial Police (OPP) has an urban search and rescue team as well as a chemical, biological, radiological, nuclear, and explosive (CBRNE) team that is collectively known as UCRT.<sup>64</sup> The UCRT team is available to the province on request as long as it is not otherwise occupied.<sup>65</sup>

The OPP team is located in Bolton, Ontario, a few kilometres north of Toronto. Therefore, the province's entire inventory of urban search and rescue assets is located in the Greater Toronto Area. The cities of Ottawa and Thunder Bay each operate their own medium-level search and rescue team.\* The province has not signed a memorandum of understanding with either city, and, therefore, these teams are not deployable by the province.<sup>66</sup>

Municipalities in Ontario operate nine CBRNE teams in all. The cities of Toronto, Ottawa, and Windsor have level 3 teams,<sup>†</sup> and the cities of Sault Ste. Marie, Thunder Bay, Cornwall, Peterborough, North Bay, and Kitchener / Cambridge / Waterloo have level 2 teams.<sup>67</sup>

The cost of deployment by the province of any of the specialized teams, whether urban search and rescue or CBRNE, is borne by the province, not the municipality.<sup>68</sup>

## Provincial Emergency Operations Centre

The Provincial Emergency Operations Centre (PEOC) is located within the Ministry of Community Safety and Correctional Services in Toronto and is managed by Emergency Management Ontario. It is staffed at all times.<sup>69</sup> Ontario's Provincial Emergency Response Plan calls for potential or actual emergencies to be reported promptly to the centre. These reports may come from many sources, including municipalities or other ministries.<sup>70</sup>

Ontario has provided a description of how Emergency Management Ontario (EMO) and the PEOC respond to an emergency declaration:

When a Head of Council declares an emergency, the province must be notified. Typically a municipality will notify the province via a telephone call/fax to the 24/7 Duty Office in the Provincial Emergency Operations Centre (PEOC).

When the PEOC Duty Officer receives a declaration of an emergency, a series of questions are posed to the person notifying the PEOC to verify contact information, situational details and to determine if any provincial assistance is being requested by the municipality. If provincial assistance is required, the PEOC Duty Officer will notify the applicable provincial officials regarding the request and the circumstances thereof.

During normal business hours, Emergency Management Ontario staff in the PEOC and EMO's Operations Section will lead EMO's response to the emergency declaration. This will include creating an Emergency Information Notification (EIN) [replaced after May 2013 by an Incident Briefing Form], disseminating this document to designated provincial and ministry representatives, contacting ministry representatives who may be able to support response operations and scheduling a teleconference with impacted municipalities, ministry officials and, as necessary[,] federal departments and agencies.

Outside of normal business hours, this work follows a similar path, but is truncated due to fewer staff being readily available. The PEOC Duty Officer is in regular contact with an EMO Duty Operations Chief (DOC) and Duty Commander (DC) and these three officials would work collaboratively to create the necessary EINs and notify provincial staff of the emerging situation.<sup>71</sup>

When a municipality declares an emergency, all the various ministry emergency management coordinators are notified by the PEOC. A ministry may choose to send staff to the event if it has implications for its mandate.<sup>72</sup>

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\* Urban search and rescue teams are classified as heavy, medium, or light, based in part on their capacity to operate. These distinctions will be explained in greater detail later on in this Report.

† These levels refer to National Fire Protection Standard 472, which covers minimum competencies of persons responding to incidents involving hazardous materials. Level 3 refers to the technician level, whereas level 2 to operational level. Further details are explained later in the Report.



## Emergency Management Ontario

Emergency Management Ontario (EMO) is the organization within the Ministry of Community Safety and Correctional Services with the responsibility to monitor, coordinate, and assist with the promotion, development, implementation, and maintenance of emergency management programs in Ontario at both the municipal and the provincial ministry levels. This responsibility includes the coordination of these programs with the federal government. In fulfilling this special coordination role, EMO coordinates provincial emergency response through the PEOC when required and provides advice and assistance to communities and ministries in all areas of emergency management. This assistance includes regular contact with municipalities to assess their compliance with the requirements of their particular emergency management program.<sup>73</sup>

EMO also maintains the Provincial Emergency Response Plan and the Provincial Nuclear Emergency Response Plan. The Provincial Emergency Response Plan must be fully reviewed, amended, and brought forward for ministerial approval at least once every four years.<sup>74</sup> As discussed, EMO has also developed an emergency response plan specifically for structural collapses – the *Provincial Emergency Response Plan for Building Structural Collapse 2010*.<sup>75</sup>

The *Emergency Management and Civil Protection Act* provides for the appointment of a chief of EMO, who, under the direction of the minister of community safety and correctional services, “is to be responsible for monitoring, coordinating and assisting in the development and implementation of municipal and provincial emergency management programs throughout Ontario.”<sup>76</sup>

EMO has field officers throughout the province who live and work in the geographical area they serve. They can offer subject matter expertise, support, and advice to the community emergency management program coordinators located within their respective areas.<sup>77</sup>

During an emergency, whether declared or not, an EMO representative may be deployed to a community to act as a liaison and to provide emergency management advice to council and senior staff. Other provincial staff may be deployed to provide additional advice, assistance, and services, under the coordination of EMO.<sup>78</sup> Such deployed staff are referred to by the Government of Ontario as the EMO Provincial Emergency Response Team (PERT), primarily made up of EMO field officers.<sup>79</sup>

EMO also has training available for all emergency management personnel in Ontario (including provincial and local emergency management personnel and first responders). Some of the courses available are as follows:<sup>80</sup>

- Basic Emergency Management Course, which covers all the basic principles of emergency management.
- Basic Emergency Management Instructor Course, which enables the candidate to be a certified basic emergency management instructor.
- Community Emergency Management Coordinators Course, which provides specific training to enable the designated community emergency management coordinator to administer the municipality's emergency management program.
- Incident Management System (IMS) courses, which provide a progressive learning system to train emergency responders in how to perform specific emergency management functions on a coordinated basis during emergency operations. Five IMS courses were available in Ontario at the time of the Commission hearings.

## Office of the Fire Marshal

The Office of the Fire Marshal, along with the Ontario Provincial Police and Emergency Management Ontario field officers, may be one of the first provincial-level actors involved with emergency response at the local level, either monitoring or responding directly to the emergency.

As mentioned earlier, the fire marshal is responsible for appointing “fire coordinators” for designated areas. These, in turn, establish and maintain mutual aid plans under which the fire departments that serve a designated area agree to assist each other in the event of an emergency and to perform other duties the fire marshal may assign.<sup>81</sup>

In addition to overseeing the implementation of mutual aid plans, the Office of the Fire Marshal has an Emergency Preparedness and Response Unit. This unit is designed to deal with situations where individual fire departments need to respond to incidents beyond their capabilities and beyond the capabilities of the mutual aid system.<sup>82</sup>

The unit responds on a full-time (24/7) basis to requests for assistance from municipal fire departments, including heavy urban search and rescue. Personnel in the Office of the Fire Marshal assess the need of a particular situation to ensure that the appropriate resource is deployed. In addition, program specialists from the unit are available to be deployed principally for liaison and for supporting the operations.<sup>83</sup>

Carol-Lynn Chambers was the operations manager of the Emergency Preparedness and Response Unit at the Office of the Fire Marshal at the time of the collapse. She explained that, typically, a local fire chief would contact the Provincial Emergency Operations Centre, which in turn would contact the operations manager. She would then get the phone number of the fire chief and call the chief directly to discuss what was needed, activate the appropriate response, and, if desirable, allocate any of her staff. She would then advise the Provincial Emergency Operations Centre of the appropriate response, which in turn would advise the commissioner of community safety.<sup>84</sup>

Other resources available through the Office of the Fire Marshal include

- advice, technical assistance, and equipment for hazardous material emergencies; and
- support for other major emergencies, in various forms, including portable lighting and generator support, radio / communications equipment, and incident documentation.<sup>85</sup>

Finally, the Office of the Fire Marshal can be involved with the operation and deployment of the Toronto Heavy Urban Search and Rescue team, as discussed further below.<sup>86</sup>

## Mutual assistance between provinces and territories

There are also mutual assistance agreements between the provinces and territories in Canada. A Memorandum of Understanding on Jurisdictional Emergency Management Assistance has been approved by all provinces and territorial ministers responsible for emergency management. This memorandum provides the framework within which provinces and territories would provide support to other Canadian jurisdictions.<sup>87</sup>

Heavy urban search and rescue teams are located in Toronto, Vancouver, Calgary, and Brandon, Manitoba.<sup>88</sup> If a province needed the assistance of any of these teams, a province-to-province request would be made under this memorandum of understanding. The expectation is that the team will be deployed if it is available.<sup>89</sup>

## The role of the federal government

If an emergency requires support or resources beyond what a municipality or the province is capable of providing, the province can make a formal request for assistance from the federal government. Municipalities may not apply directly for federal emergency assistance, which would include assistance from the military.<sup>90</sup>

The federal government intervenes in an emergency in a province only when requested to do so by provincial emergency management organizations or when an emergency clearly will have an impact on areas of federal jurisdiction<sup>91</sup> – such as emergencies created by acts of terrorism.<sup>92</sup>

## Incident Management System: the system as it is intended to work

The Incident Management System (IMS) is a doctrine sponsored by the Government of Ontario which is intended to provide a single, province-wide system for emergency management and to be used by the various response organizations in the province. In this section of the Report, I describe in summary form how IMS is intended to operate. I will not, at this time, comment either on its efficacy or the extent to which it was followed in the response to the collapse of the Algo Mall. That analysis will come later in the Report.

## Background and purpose of the Incident Management System

The Government of Ontario developed the IMS doctrine in an attempt to coordinate emergency management among the affected community and the related organizations, institutions, and industries. The stated objective is to provide a “flexible, scalable and consistent IMS structure and process for all levels of government, emergency response organizations, communities, ministries, NGOs and the private sector.”<sup>93</sup>

The IMS was sponsored by Emergency Management Ontario and developed by a steering committee and several working groups made up of representatives from organizations involved in emergency response, including fire services, police services, and governmental departments. Their work produced the IMS doctrine, a 140-page document in which the system is described. The IMS doctrine was ultimately approved on January 30, 2009, by the Ontario government.<sup>94</sup>

The impetus for developing this doctrine arose following the terrorist attacks in New York City, Pennsylvania, and Washington, DC, in September 2001. In the wake of that event, as well as other more recent emergencies including the 2003 Severe Acute Respiratory Syndrome (SARS) pandemic, the provincial government struck a commission to review Ontario’s emergency response capabilities and to make recommendations for improvement.<sup>95</sup> The commission noted that the response to SARS, which was principally a health emergency, involved many different disciplines, including police and fire services. In view of the myriad organizations that can be called upon to respond to an emergency in Ontario, the commission recommended that a common protocol system be put in place so that the management of an emergency involving different response organizations could be coordinated more easily.<sup>96</sup>

The IMS doctrine was originally premised on a similar emergency response regime, the Incident Command System (ICS), which had been developed by the fire service.<sup>97</sup> The IMS was developed for the purpose of expanding the ICS so that other responding organizations could be similarly organized in an emergency.<sup>98</sup>



In emergencies such as SARS and, indeed, the response to the collapse of the Algo Mall, different response organizations, which do not typically coordinate their operations, are called upon to work together. The IMS purports to coordinate a uniform response protocol among entities responding to a particular emergency. It seeks to establish a standardized organizational structure that may be distinct from the individual responding organization's day-to-day administrative structures. The stated purpose of having a standardized organizational structure is to help different organizations work together in an emergency response – including by establishing clear terminology and roles.<sup>99</sup>

## The Incident Management System is not mandatory

As noted, one of the stated primary purposes behind the development of the IMS doctrine was to provide one standardized emergency response system across Ontario so that different entities, individuals, and organizations can more effectively respond to emergency incidents.<sup>100</sup> Indeed, the provincial government “recommends” that the IMS be used for managing *all* incidents.<sup>101</sup> However, the IMS is not mandatory; rather, it is voluntary.<sup>102</sup> In fact, it provides that responders are able to use only those aspects of the doctrine that are suited to a given incident.<sup>103</sup>

One of the stated primary purposes behind the development of the IMS doctrine was to provide one standardized emergency response system across Ontario so that different entities, individuals, and organizations can more effectively respond to emergency incidents.

As a practical matter, therefore, organizations that are involved in emergency response – such as fire, police, and emergency management services – are not required to use the IMS doctrine in their day-to-day operations. It exists theoretically and may be used within emergency response organizations selectively, or, presumably, not at all. In his evidence before the Commission, Mr. Hefkey was not able to advise what percentage of emergency response organizations in the province actually use the IMS doctrine in their operations.

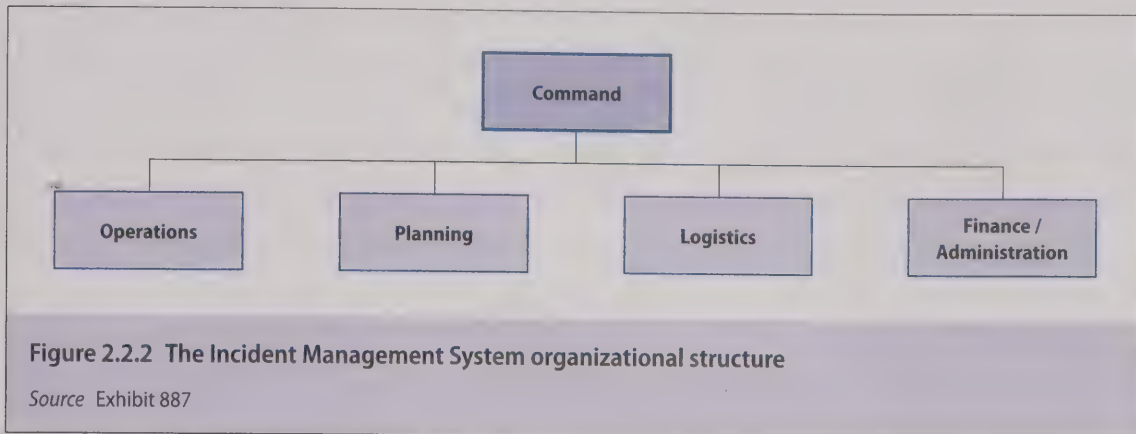
It follows that certain emergency response organizations use IMS more than others do and have a correspondingly greater familiarity with its components. Accordingly, not all response organizations share the same level of understanding of the doctrine.

In introducing the doctrine, the province recognized that achieving a standardized IMS that “cuts across organizational boundaries may necessarily involve cultural shifts, over time, among some incident management practitioners.” The province also stated that “province-wide implementation is envisaged over time ... The expectation is that gradually all of Ontario's response organizations will implement the IMS and will train their personnel in the content of this doctrine to the extent deemed necessary by their respective organizations.”<sup>104</sup>

The extent to which Ontario's emergency responders exhibited familiarity with the IMS will be considered later in this Report.

## Incident Management System organizational structure and management functions

Five major management functions provide the foundation on which the IMS is structured. These five are command, operations, planning, logistics, and finance and administration.<sup>105</sup> These functions must form part of every incident response.<sup>106</sup> The IMS literature depicts the structure as in figure 2.2.2.



## Command

Command is the paramount organizational component of the IMS structure. It is the act of directing, ordering, or controlling the operation of an emergency response.<sup>107</sup> Incident command is responsible for managing the response to an emergency event.

Under the IMS doctrine, there are two models of incident command that may be used during an incident: single and unified. A single command model may be arrived at by default when only one jurisdiction or organization is involved; by the nature of the emergency; or by legislation, if the responsibility is legally that of a single jurisdiction or organization.<sup>108</sup>

In a unified command situation, two or more organizations that are participating in the emergency response designate members to be a part of the unified command. Those participants are intended to work together to establish and implement a common set of objectives. It is, in essence, command by committee. Unified command is to be used on rare occasions when incident decision-making is complex, interdependent, and a single command cannot be established.<sup>109</sup>

## The incident commander

The individual who exercises the command function is known as the incident commander. An incident commander has overall authority and responsibility for conducting emergency response operations and is responsible for the management of all operations at the location of the incident. In a single command situation, only one person will exercise the function of the incident commander at any one time. Therefore, while several jurisdictions may respond, there will be only one incident commander.<sup>110</sup>

The IMS is intended to operate so that all responders from different jurisdictions and organizations are working toward a common goal. It contemplates the integration of resources and personnel, with the result that the incident commander may be from a different service than many of the other responders. This arrangement creates a cultural anomaly where persons can be commanded by individuals who are not from their own organization or who may even hold a lower rank.

Assuming incident command means taking overall responsibility for managing the incident and providing the overall leadership. According to the IMS doctrine, command must be clearly established at the beginning of an incident and maintained until the end.<sup>111</sup>

Although there is only one incident commander, that function may transfer from one individual to another. Any such transfer of command always requires that there be a full briefing for the incoming incident commander and notification to all personnel that a change in command is taking place.<sup>112</sup>

The incident commander's responsibilities include

- ensuring the safety of all responders;
- assessing and reassessing the situation, which may require obtaining information from other levels of response;
- determining goals, strategies, objectives, and priorities appropriate to the level of response;
- establishing an appropriate command structure using the IMS;
- coordinating all incident management activities;
- coordinating overall incident activities with other levels of response;
- establishing and maintaining liaison with supporting or assisting organizations;
- providing information to and briefing senior and elected officials as required;
- establishing or activating Incident Management System facilities;
- establishing an operational planning cycle;
- approving an incident action plan (described in greater detail below);
- managing incident resources;
- authorizing the release of emergency information to the public in co-operation with the other levels of response, including information that would be disseminated by a Community Control Group; and
- ordering incident demobilization.<sup>113</sup>

## **Operations, planning, logistics, and finance and administration**

Under the incident commander are the operations, planning, logistics, and finance and administration spheres of responsibility. Each of these sections is commanded by a section chief. The section chiefs may well be from different services than the incident commander.

The Operations Section is intended to implement the incident action plan.<sup>114</sup> This section is responsible for assigning and supervising all resources assigned to an incident, and it should work closely with Command to coordinate operational activities.<sup>115</sup>

The Planning Section is intended to develop the incident action plan. Its responsibilities may include collecting, evaluating, analyzing, and disseminating information related to the emergency response, as well as maintaining incident documentation, tracking resources assigned to the incident, and conducting long-range and/or contingency planning.<sup>116</sup>

The Logistics Section is intended to provide supporting resources to the emergency response. Such support could include electronic communications, equipment, medical-related assistance, and other supplies such as food.

The Finance and Administration Section is intended to provide the financial and cost analysis support to the incident.<sup>117</sup>

The IMS is designed to be an organizational model that is scalable – that is, adjustable to respond to the magnitude of a response. It attempts to provide a template of how the organizational structure within these primary management functions can expand and contract as the situation dictates.



## The incident action plan

Establishing an incident action plan is one of the major responsibilities for an incident commander. Although it is developed by the Planning Section, it must be approved by the incident commander. Every incident must have an incident action plan. Its purpose is to provide *all* incident supervisory personnel with direction for the actions that are to be implemented in the course of the emergency response.<sup>118</sup>

The essential elements of an incident action plan, as stated in the IMS, are

- a statement of objectives expressing in a measurable manner what is expected to be achieved;
- clear strategic direction;
- the tactics to be employed to achieve each overarching incident objective;
- a list of resources that are assigned;
- the organizational structure / chart; and
- safety guidelines or requirements.<sup>119</sup>

While an incident action plan is required in all incidents, the nature of a given emergency response should dictate the level of detail in which the plan is prepared. According to the IMS doctrine, incident action plans can be oral or written. An oral plan may be sufficient when managing a simple incident, but a written plan should be used when dealing with complex incidents.<sup>120</sup> A simple incident is one that can be handled routinely, requires few resources, and is relatively short in duration. Managing simple incidents does not normally require dependence on resources outside those that are available in the immediate area.<sup>121</sup>

Complex incidents typically arise in one of two ways: they are either immediately complex (for example, a tornado that passes through a community), or they become complex (as in an isolated disease that becomes a pandemic). Complex incidents usually have some or all of the following characteristics:

- prolonged duration requiring major changes in personnel or involving successive operational periods;
- breadth of scale requiring a large number of resources;
- multiple jurisdictions involved;
- special knowledge and/or training required to resolve;
- significant risk to the responders or the jurisdiction as a whole;
- potential to cause widespread damage;
- more complex organizational structure required; and
- formal planning necessary.<sup>122</sup>

Whether for a simple or a complex emergency response, an incident action plan is developed through the following steps:

- assessment of the situation: “size-up” the situation to determine the nature of the problem;
- establish incident objectives and strategy: determine the overall plan to meet the objectives of the emergency response;
- develop the plan: ascertain the tactics that will be required to carry out the strategy, including detailing how resources will be deployed and developing an organizational structure for the response;
- implement the plan: orders and directives are issued from incident command and the Operations Section for the purpose of carrying out the incident action plan; and
- evaluation: constantly assess and re-evaluate objectives, strategies, and tactics to ensure the effectiveness of the plan’s implementation.<sup>123</sup>

## Planning cycle

As part of the development and implementation of the incident action plan, the IMS provides for a planning cycle. Its primary purpose is to facilitate, through designated meetings and forms, continuous evaluations and assessments of the objectives, strategies, and tactics that are developed in the plan and that are implemented in the course of the emergency response.<sup>124</sup>

As depicted in IMS literature, the planning cycle is intended to function in accordance with the organogram set out in figure 2.2.3:

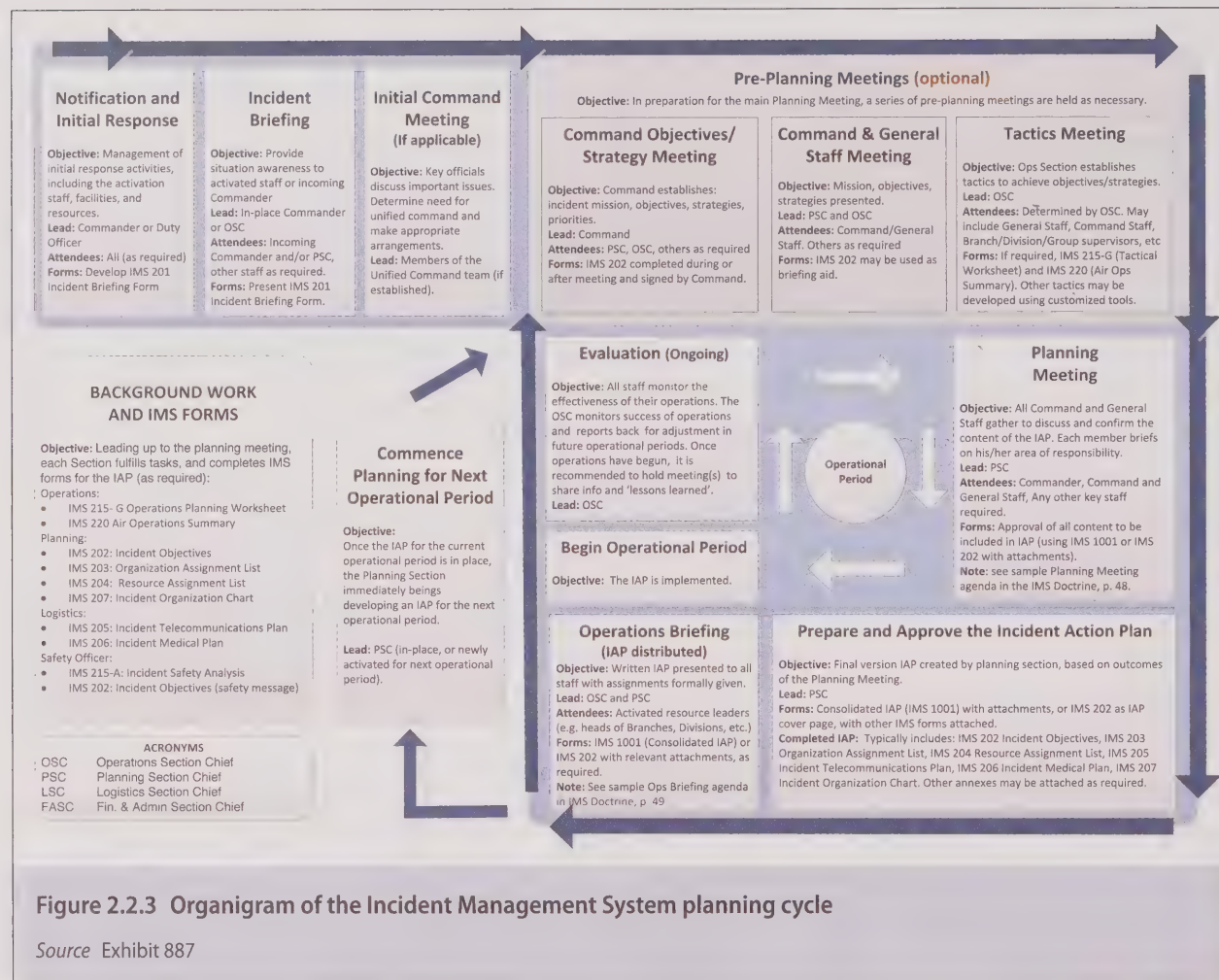


Figure 2.2.3 Organogram of the Incident Management System planning cycle

Source Exhibit 887

The incident action plan is to be developed at a planning meeting. Individuals involved in the command and operations of the emergency response are to attend the meeting. Following the meeting, an incident action plan is to be prepared and approved. As noted, the plan can be written or oral. However, the more complex the incident, the greater the necessity for the plan to be written.<sup>125</sup>

Following preparation and approval of the incident action plan, the next suggested step in the IMS planning cycle is an operations briefing. It is intended to ensure that everyone in the emergency response structure is aware of the strategy and the tactics that will be deployed in the execution of the plan.<sup>126</sup>

Once the operation has started, a subsequent element of the planning cycle is referred to as ongoing evaluation. Its intended purpose is to ensure that the operation is focused and refined so that the incident command can determine whether any strategies or tactics need to be altered.<sup>127</sup> It is in the on-going evaluation process that the incident command considers contingency plans, or “Plan Bs,” as necessary.<sup>128</sup>

## Training

The Government of Ontario currently provides training courses in the Incident Management System doctrine. These courses include

- IMS 100, an introduction to the doctrine;
- IMS 200, a two-day course that trains people in dealing with the application of the IMS to simple incidents;
- IMS 300, an intermediate three- to four-day course on the application of the IMS involving multiple response organizations; and
- IMS 400, which is still under development and which is intended to be an advanced course related to complex emergency responses.<sup>129</sup>

## Overview of key players in the Elliot Lake response

### Elliot Lake Fire Department

The Elliot Lake Fire Department is a composite fire service made up of both full-time and volunteer firefighters.<sup>130</sup> In 2012, it was composed of the chief, his assistant, eight full-time, and about 20 volunteer firefighters.<sup>131</sup> Chief Paul Officer testified that the department follows the Incident Management System.

### Training and equipment

The Elliot Lake Fire Department does not train for structural collapses because such events are not part of its mandate. Pursuant to section 2(1)(b) of the *Fire Protection and Prevention Act*, the municipal council sets the level of service that the local fire department delivers to a municipality. That said, the firefighters would receive, through their regular training, an awareness level of competency for structural collapses.<sup>132</sup>

Because the Mall collapse was beyond the mandate and training level of the Elliot Lake Fire Department, it is not surprising – as will be reviewed in detail later in the Report – that it did not have the equipment necessary to deal with the collapse. Chief Officer pointed out that the fire service in neither Sudbury nor Sault Ste. Marie had any equipment that would have been of assistance in dealing with the collapse.<sup>133</sup>

Although the Office of the Fire Marshal provides a common radio frequency that allows different fire services to communicate with one another, there was no common frequency that would allow the Elliot Lake Fire Department to communicate with other non-fire service responders.<sup>134</sup>

Full-time firefighters participate in on-the-job training. In general, they are expected to spend more time training than do volunteer firefighters. Anyone wanting to become a volunteer firefighter must undergo a background check and meet the physical fitness requirements. All candidates must complete a 24-hour course that, for the most part, acquaints them with the personal protective equipment typically used in the course of a firefighter's duties. Completion of this training does not, at that point, enable volunteers to respond to fire calls. Rather, candidates are referred to as reserves, in an introductory phase that takes, on average, about three months to



complete. During that time, they are integrated into the service's training before they are judged competent to attend at a fire, albeit in a very limited capacity. Ultimately through training programs, courses, and experience attending at fires, volunteers can achieve a provincial certification and thereby become eligible for full-time employment as firefighters in Ontario.<sup>135</sup>

There is an expectation that volunteers will attend a minimum of eight hours of training a month – a commitment that gradually lessens to four hours a month as they become more experienced. This training is augmented by the experience gained by attending fires.<sup>136</sup>

Since Paul Officer became the chief of the Elliot Lake Fire Department, all new full-time firefighters hired have come from the ranks of the department's volunteers. City Council has insisted on an open competition, so the volunteers compete against community college graduates, and the volunteers have consistently scored higher.<sup>137</sup>

## Tactical priorities

When responding to a call, firefighter safety is a top priority. The overall tactical priorities of the fire department are expressed in the following phrases from Chief Officer's testimony:<sup>138</sup>

- We will risk our lives a lot, in a highly calculated manner, to protect saveable lives.
- We will risk our lives a little, in a highly calculated manner, to protect saveable property.
- We will *not* risk our lives at all, to save lives or property that are already lost!<sup>139</sup>

Consequently, the decisions made about how an emergency will be dealt with involve weighing the risk against the reward.\*

## City of Elliot Lake

As described above, the *Emergency Management and Civil Protection Act* requires every municipality in Ontario to develop and implement an emergency response plan. In this section of the Report, I will provide an overview of the plan developed by the City of Elliot Lake. I will discuss later in the Report how the plan was actually implemented in the response to the Mall collapse.

## Emergency response plan

Since 1970, the City has had an emergency response plan in one form or another.<sup>140</sup> The plan in place at the time of the collapse was originally adopted through a by-law in 2005 and was amended in 2006 in response to the implementation of the *Emergency Management and Civil Protection Act*.<sup>141</sup>

The plan is a 42-page document<sup>142</sup> and was created using a template provided by Emergency Management Ontario.<sup>143</sup> The introduction to the plan states:

The emergency response plan (ERP) has been developed in order to facilitate a timely and effective mobilization of resources in order to respond to an emergency. Every official, municipal department and agency must be prepared to carry out assigned responsibilities in an emergency and are [*sic*] expected to be familiar with those responsibilities.<sup>144</sup>

.....

\* Officer testimony, August 21, 2013, pp. 21532–3; Roger Jeffreys, the provincial engineer with the Ministry of Labour, testified to the same effect: "[T]he level of risk that a worker would expose himself or herself to would appropriately be higher than in a situation where they were not attempting a rescue." Jeffreys testimony, October 3, 2013, pp. 28061–2.

The plan was prepared to provide key City officials, agencies, and departments with important emergency response information related both to arrangements, services, and equipment and to roles and responsibilities during an emergency.<sup>145</sup>

The plan is supplemented by an annex – a more detailed document than the plan itself. The annex provides direction on how things are to be done, rather than simply identifying the responsibilities of a group or a person.<sup>146</sup> For example, it provides detailed instructions on how actually to set up an emergency operation centre during an emergency, and it contains an emergency information plan that includes step-by-step instructions for organizing a news conference.

### Community Control Group

The plan defines the Community Control Group (CCG) as the group of officials who are responsible for coordinating the provision of essential services necessary to minimize the effects of an emergency on a community. The members are as follows:

- mayor
- chief administrative officer, as the emergency operations manager
- OPP
- East Algoma emergency management coordinator
- fire chief
- East Division supervisor of the Emergency Medical Services
- public health inspector
- director of operations of the City
- director of growth and opportunity development, as duty officer, and
- emergency management coordinator

The plan provides that the CCG may add resource personnel to its membership as required, including a Red Cross representative, the emergency information officer, an Emergency Management Ontario representative, liaison staff for provincial ministries, and any other officials, experts, or representative from the public or private sector as deemed necessary.<sup>147</sup>

The plan identifies various responsibilities of the CCG including

- advising the mayor on the need to designate all or part of a city an emergency area;
- ensuring support to the incident commander by offering staff, equipment, and resources as required;
- ordering, coordinating, and/or overseeing the evacuation of residents;
- arranging for services and equipment from local agencies not under community control; and
- arranging for the expenditure of money required to deal with the emergency.

A common responsibility for all members is that they keep a personal log of all actions taken.<sup>148</sup> The annex stresses the importance of the CCG meetings. They provide the opportunity to bring members up to date as to what has occurred and what has been accomplished.<sup>149</sup>

The plan allows only members of the CCG or their alternates to initiate the process of notifying the CCG's membership of a real or potential emergency. The CCG member with the information contacts the Elliot Lake Fire Department, asking it to inform all other members by means of the pre-prepared notification list.<sup>150</sup>

## Responsibilities of some of the key players of the Community Control Group

As set out in the plan, the mayor or acting mayor is charged with

- providing overall leadership in responding to the emergency;
- declaring an emergency within the designated area;
- notifying Emergency Management Ontario of the declaration of both the emergency and the termination of the emergency;
- ensuring that the members of council are advised of the declaration and the termination of an emergency and are kept informed of the emergency situation;
- ensuring that the public and other government agencies are kept informed by issuing news releases and public announcements on advice from the CCG; and
- declaring the emergency terminated (council may also terminate the emergency).<sup>151</sup>

In addition, the mayor or an alternate acts as the media spokesperson.

The plan provides that in an emergency, the City's chief administrative officer becomes the Emergency Operations Centre manager, whose duties include

- coordinating all operations within the Emergency Operations Centre;
- chairing the CCG in the absence of the mayor or deputy mayor;
- ensuring an operating cycle for CCG members to gather at regular intervals;
- checking the operational status of each department;
- ensuring council is kept informed; and
- approving major announcements in conjunction with the head of council and approving media releases in consultation with the CCG and the emergency information officer.<sup>152</sup>

The OPP East Algoma emergency management coordinator's responsibilities include

- establishing a site command post with communications to the Emergency Operations Centre;
- establishing and providing security for the inner and outer perimeters;
- ensuring crowd management; and
- assisting with compiling a vital services directory and updating the directory annually.<sup>153</sup>

The fire chief's responsibilities include

- activating the emergency notification system through the Elliot Lake Fire Department; and
- providing the CCG with information and advice on firefighting and rescue matters.<sup>154</sup>

The Emergency Operations Centre duty officer's responsibilities include

- ensuring that all important decisions and actions taken by the CCG are recorded;
- coordinating all logistical needs of the Emergency Operations Centre;
- ensuring that the personal log books for all CCG members are made available to them; and
- maintaining a personal log of all actions taken.<sup>155</sup>



The emergency information officer's responsibilities include

- liaising with the CCG to obtain up-to-date information for media releases;
- drafting media releases for approval;
- coordinating interviews and organizing press conferences;
- establishing a regular communication link between the CCG and any other media coordinators; and
- ensuring that all information released to the media and the public is consistent and accurate.<sup>156</sup>

## Emergency Operations Centre

As noted earlier, a municipality's Emergency Operations Centre is where the CCG meets for the purpose of supporting the response to the emergency. The annex sets out both a primary and an alternate location for the Emergency Operations Centre. In Elliot Lake, the primary location was the ground-floor committee room at city hall. Supplies are kept there to allow the centre to be set up quickly. These items include the personal log books for all members of the CCG.<sup>157</sup>

## East Algoma OPP

The general policing functions in the City of Elliot Lake are carried out by the members of the OPP's East Algoma detachment. This detachment was under the control of Insp. Percy Jollymore at the time of the collapse.

## City of Toronto Heavy Urban Search and Rescue team

The City of Toronto operates a Heavy Urban Search and Rescue team that is known by various names. It is referred to as Toronto HUSAR, Canada Task Force 3, or TF3. The latter two names are how it is known within the national urban search and rescue program. In this Report, I will use HUSAR/TF3 to refer to this team. However, at the Commission's hearings, all three names were used interchangeably by witnesses and counsel. Consequently, the other two names may occasionally appear in this Report.

The primary purpose of HUSAR/TF3 is to rescue persons trapped in collapsed structures.<sup>158</sup> "Urban search and rescue" is the generic term used to describe a group of specialized rescue skills supplemented by search, medical, and structural assessment resources combined in a mobile, highly integrated team.<sup>159</sup>

**The primary purpose of HUSAR/TF3 is to rescue persons trapped in collapsed structures.**

Tony Comella is a captain with the Toronto Fire Service. He is also the team coordinator for HUSAR/TF3. He provided the Inquiry with background information concerning the team in a PowerPoint presentation.<sup>160</sup>

## Classification of Urban Search and Rescue teams

Public Safety Canada has developed a Canadian urban search and rescue (USAR) classification guide which is set out in part below. The guide describes the capabilities that USAR teams at the light, medium, and heavy levels bring to disaster response. HUSAR/TF3 is classified as a heavy urban search and rescue team (fig. 2.2.4).<sup>161</sup>

## General Team Notes

- All National HUSAR task forces, including CAN-TF3 Toronto HUSAR, meet the national Urban Search and Rescue (USAR) classification guide for Heavy USAR operations level as directed by Public Safety Canada.
- 76 personnel is a full deployment for CAN-TF3. If responding by road in Ontario, we would add eight logistics drivers for a total of 84 personnel.



### Light/Medium/Heavy USAR Capabilities

Operational USAR Level and area of response	Time Period (sustained response)	Structural Response (type of construction teams are equipped and trained to search and stabilize)	Medical Response
Light – Within jurisdiction	One operational shift – 12 hours	<ul style="list-style-type: none"> <li>• Structural wood systems</li> <li>• Light metal components</li> <li>• Un-reinforced masonry which supports floors, other wall cladding and roofing systems</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to deal with minimum/maximum</li> <li>• Medical support To Team</li> <li>• Medical triage &amp; assistance to victims</li> </ul>
Medium – Within mutual aid boundaries	One operating day - 24 hours	<ul style="list-style-type: none"> <li>• All collapsed or failed structures</li> <li>• Includes search and rescue operations for heavy timber, reinforced masonry construction, or steel frame</li> </ul>	<ul style="list-style-type: none"> <li>0 Critical injuries</li> <li>5 Moderate injuries</li> <li>10 Minor injuries</li> </ul>
Heavy – Across Canada	Up to 10 operating days - Re-supplied within 3 days	<ul style="list-style-type: none"> <li>• All collapsed or failed structures</li> <li>• Includes structural engineering and rigging for massive structural collapse</li> </ul>	<ul style="list-style-type: none"> <li>2 Critical injuries</li> <li>5 Moderate injuries</li> <li>10 Minor injuries</li> </ul>



Public Safety  
Canada

Sécurité publique  
Canada

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Figure 2.2.4 The Urban Search and Rescue organizational structure

Source Exhibit 9278

## History of the Toronto HUSAR

HUSAR/TF3 was first conceived in 1999, though at that time, it had no team members and no equipment.<sup>162</sup> The events of September 11, 2001 (9/11), provided the impetus for funding<sup>163</sup> which allowed HUSAR/TF3 to make capital expenditures such as the purchase of the necessary equipment to begin its training program and its availability to deploy.<sup>164</sup> The federal funding came through the Joint Emergency Preparedness Program (JEPP).<sup>165</sup>

The financial support of the federal and provincial governments, as well as the City of Toronto, allowed the team to purchase the equipment and train its members to the extent that it is (at least for now) capable of deployment anywhere in Canada to respond to structural collapses.<sup>166</sup> In this capacity, HUSAR/TF3 is part of Canada's national urban search and rescue program.<sup>167</sup> Provincial deployments are governed by a memorandum of understanding between the province and the City of Toronto.<sup>168</sup>

The significant milestones in the history of the HUSAR/TF3 team include the following events:

- 2002: The future team instructors begin their structural collapse training in Vancouver.<sup>169</sup>
- 2003: The training of team instructors in structural collapse is completed at Texas A&M University
  - The team is able to deploy its instructor group and equipment locally.
- 2004: Component agencies (Toronto Fire Service, Toronto Police Service, Toronto Emergency Medical Services, and Toronto Water) begin to supply members to the team.
- 2005: The team receives funding from the province for training.<sup>170</sup>
  - 109 team members receive the required level of training to deploy to a structural collapse.
  - Doctors are integrated into the team.
  - The team and its equipment are now deployable anywhere within the province.
- 2006: The team and the equipment are deployable nationally.
- 2011: The team is deployed by the province to Goderich for a structural collapse caused by a tornado.
- 2012: The team deploys to Elliot Lake for the collapse of the Algo Mall.
- 2013: Funding from the federal government ends.<sup>171</sup>

In 2012, the federal government announced the end of the JEPP funding, which came into effect in April 2013. The annual federal funding for HUSAR/TF3 varied between a high of \$1.4 million and a low of \$460,000. The money was used mainly for the purchase of equipment, while the provincial contributions were reserved for training.<sup>172</sup>

The effect of the loss of the federal funding will be felt when capital expenditures have to be made to replace equipment. In addition, other sources of funding will have to be found when costs associated with maintaining the national presence need to be incurred (e.g., transportation for training evaluation and meetings).<sup>173</sup>

## Composition of the Toronto HUSAR

The Toronto HUSAR team is composed primarily of persons employed by the City of Toronto. The search component, which includes the use of canine units and technical equipment, is staffed by members of the Toronto Police Service. The rescue component is the responsibility of the Toronto Fire Service. The medical component uses paramedics from Toronto Emergency Medical Services and doctors from the Sunnybrook Osler Centre for Pre-hospital Medicine. Toronto Water manages the heavy equipment, which includes rigging but not the actual operation of heavy equipment. Structural engineering services are provided by Stephenson Engineering.<sup>174</sup> The primary responsibilities of the structural engineer are to determine the stabilization requirements of a structure which are beyond the scope of the team's technical knowledge. The structural engineer is not expected to make conclusions about the structure's safety – which is understood not to be safe.<sup>175</sup>

This division of responsibilities takes advantage of the specific skills and training that each organization possesses. The team has more than 100 members in all, with approximately 70 from the fire service.<sup>176</sup> Rescue is the primary component in most deployments.<sup>177</sup>

## Training standards

The training of HUSAR/TF3 members is related primarily to structural collapse. The training standard that has been adopted is that developed by the US National Fire Protection Association (NFPA).<sup>178</sup> Two related standards in particular are relevant to structural collapse: NFPA 1670, "Standard on Operations and Training for Technical Search and Rescue Incidents," and NFPA 1006, "Standard for Technical Rescuers Professional Qualifications."<sup>179</sup> NFPA 1670 is an organization standard, and NFPA 1006 is a standard for individuals.<sup>180</sup>



NFPA 1670 establishes three levels of functional capability for organizations conducting operations at technical search and rescue incidents: awareness, operations, and technician, with the last being the most advanced.<sup>181</sup> According to Capt. Comella, for the organization to function at the technician level, there is no need for all

**In the case of structural collapse, the organization, in addition to the skills specifically enumerated for that category, must operate at the technician level in rope rescue, confined space search and rescue, vehicle search and rescue, trench and excavation search and rescue, and machinery search and rescue.**

members of the organization to have technician-level training. Not all members of HUSAR/TF3 have that level of training.<sup>182</sup> NFPA 1670 identifies a number of search and rescue categories, one of which is structural collapse. Each type of search and rescue has its own requirements for achieving the different levels of capability. In the case of structural collapse, the organization, in addition to the skills specifically enumerated for that category, must operate at the technician level in rope rescue, confined space search and rescue, vehicle search and rescue, trench and excavation search and rescue, and machinery search and rescue.<sup>183</sup>

In NFPA 1006, the qualifications are expressed as level 1 and level 2. According to Capt. Comella's presentation, the level 1 technical qualification is the functional equivalent to achieving the awareness / operations level of NFPA 1670, whereas level 2 is equivalent to the technician standard of NFPA 1670.<sup>184</sup>

Rescue Systems 1 and 2, programs delivered by commercial providers, constitute another pair of competency standards used by some search and rescue personnel. They do not correspond exactly to NFPA standards. Rescue System 1 aligns roughly with awareness / operations, whereas Rescue System 2 corresponds to technician level. Texas A&M Engineering Extension Service (TEEX) is one of the providers that uses that nomenclature.<sup>185</sup>

## Team member training

HUSAR/TF3 has its own training facility, designed specifically for technical rescue training. All current instruction of members is done in-house by a group of previously trained team members. The instructors group is drawn from the first members of HUSAR/TF3, all of whom received their training from outside providers.<sup>186</sup> The first step in the training of new team members is a four-hour orientation session to familiarize them with the organization's structure and mandate.<sup>187</sup> It is followed by a 40-hour structural collapse course that takes members to the operations level in those skills specific to structural collapse.<sup>188</sup>

The technical level curriculum for structural collapse consists of five core courses: shoring and stabilization (floor), shoring and stabilization (wall), breaching techniques (clean / cutting), breaching techniques (alternate / chipping), and heavy object / lift and move.<sup>189</sup> All team members, regardless of background, receive the core training.<sup>190</sup> Each core course is 20 hours long.<sup>191</sup>

Once the core training is completed, the members are expected to take skills maintenance (refresher) training.<sup>192</sup> Minimum annual training includes completing a skills maintenance course and 10 hours of online training in order to maintain good standing.<sup>193</sup> In addition, complementary training is available which allows members to be exposed to skills beyond their usual skill set.<sup>194</sup>

In an emergency, team members who have completed only one core course could be deployed.<sup>195</sup> However, they are not expected to work in the hot zone (rubble pile) unless they have completed their core training.<sup>196</sup>

According to the team training matrix (fig. 2.2.5), the goal is to have all team members trained to the technician level. However, this objective refers only to the actual skills specific to structural collapse. With respect to those other skills referred to in NFPA 1670 – for example, rope rescue – only members of the rescue component are expected to have technician-level skills.<sup>197</sup>

## Mobilization of HUSAR/TF3

HUSAR/TF3 has a mandated “stand-up time,” or mobilization time, of six hours after receiving orders to deploy. The team does not dispatch an advance team. In fact, it travels in a convoy, with most members travelling in a bus.<sup>203</sup>



On deployment, the site commander, also known as the task force commander, is the leader of the deployed team.<sup>204</sup> HUSAR/TF3 uses the Incident Management System.<sup>205</sup> Consequently, all four section chiefs report to the site commander.<sup>206</sup> The team assists the incident commander.<sup>207</sup> As was mentioned earlier, HUSAR/TF3 should report to, and be under the command of, the incident commander.

Following a deployment, HUSAR/TF3 does not conduct a formal debriefing or prepare an after-action report, though Capt. Comella agreed that both are valuable tools for improving future performance. They are not done because no funds are allocated to get the team together for a debriefing.<sup>208</sup>

## Ontario Provincial Police

The terrorist attacks of September 11, 2001, caused many governments and organizations to examine their ability to manage a terrorist incident or a major disaster. For its part, the OPP established a Provincial Emergency Response Team (PERT) in an effort to ensure that the province had the resources to strengthen and protect public safety. In 2010, the team was reorganized and given the name UCRT. As mentioned earlier, the OPP's UCRT unit combines the skills of urban search and rescue with chemical, biological, radiological, nuclear, and explosive (CBRNE) response. All its members are dedicated to their UCRT duties on a full-time basis.<sup>209</sup>

The UCRT team, as of August 2013, had funding for 28 members. When it was initially formed, it had funding for 32 members but has subsequently been downsized.<sup>210</sup> Because it is a smaller team than HUSAR/TF3, the UCRT team can deploy more quickly and can arrive at an emergency scene before HUSAR/TF3.<sup>211</sup>

The OPP has created a standard operating procedure manual (the UCRT Manual). It explains the work of urban search and rescue (USAR) as follows:

USAR teams locate trapped persons in collapsed structures and other entrapments using search dogs and electronic search equipment. USAR also involves breaching, shoring, lifting and removing structural components, the use of heavy construction equipment to remove debris, and the medical treatment and transfer of victims. USAR is a general term for a group of specialized rescue skills that are integrated into a team that includes search, medical and structural assessment resources.<sup>212</sup>

## Composition of UCRT

There are two elements within UCRT, each with responsibility for one of its two primary functions: USAR and CBRNE. On the day of the collapse, UCRT's available operating complement was 23 members.<sup>213</sup> The team included two canine handlers and five advanced-care paramedic specialists from agencies who are deployed on a part-time basis with UCRT when called out to assist. They are referred to as tactical medics.<sup>214</sup>

The command structure within UCRT is as follows: the unit commander, a staff sergeant, is in charge of the entire UCRT team. Below the unit commander, a sergeant leads both the urban search and rescue and the CBRNE elements of the team. In addition, a third sergeant is assigned in an administrative and operational support role.<sup>215</sup>

## Training of UCRT members

The UCRT Manual provides that those members of UCRT assigned as USAR specialists are to be trained and are expected to maintain the technician level of skills. Those members who are CBRNE specialists are expected to complete initial USAR training to the technician level but to maintain operations-level training.<sup>216</sup> Both elements are cross-trained in the other's skills, except for explosives.<sup>217</sup>



According to Sgt. Jamie Gillespie, the administrative sergeant of UCRT, members are all trained to the technician level of NFPA 1670 in structural collapse rescue, confined space rescue, high-angle rope rescue, and technical search.<sup>218</sup>

Originally, all the training a member received was at Texas A&M Engineering Extension Service (TEEX). In the last few years, however, only the structural collapse rescue training has been done there. At present, new members receive only level 2 (technician) training at TEEX. Before going there, they get in-house training at the OPP facility in Bolton, Ontario.<sup>219</sup> Ongoing training is also offered at the Bolton facility. In addition, the team conducts many exercises of its own and participates in provincial exercises.<sup>220</sup>

UCRT and HUSAR/TF3 have similar expertise in dealing with structural collapse issues. However, HUSAR/TF3, being a much bigger team, can sustain its operations for a longer period.<sup>221</sup>

## Deployment of UCRT

The UCRT unit can be deployed as a result of a request from within the OPP or from other police services, municipalities, or the province. All requests, however, must be approved through the OPP chain of command<sup>222</sup> and in particular by the manager of the OPP Field Support Bureau's Emergency Management and Planning Section. The UCRT unit commander has the ultimate responsibility to determine what resources are deployed once approval has been given. In the case of a response to a structural collapse, it is expected that the USAR sergeant or a senior USAR technician will be consulted in making that decision.<sup>223</sup>

The USAR sergeant or his or her substitute in command activates the required personnel and decides whether an advance team is required for reconnaissance purposes. Before deployment, or as soon as practicable thereafter, a briefing is conducted so that all responders receive all the relevant information.<sup>224</sup>

On arriving at the scene of an emergency, the USAR sergeant is expected to go to the command post, if there is one, and receive a briefing. Once briefed, it is suggested that the team's personnel attempt to begin search and rescue operations as quickly as possible. According to the UCRT Manual, previous experience has shown that most survivors are rescued early in the course of an emergency response.<sup>225</sup>

The OPP has adopted the Incident Management System as the emergency management tool it will employ.<sup>226</sup>

## The Ministry of Labour in an emergency response

It may come as a surprise to some readers that the Ministry of Labour cannot only play a role but is conferred with specific authority at the scene of an emergency response. Indeed, the scope of the ministry's legislative powers at a rescue may even surprise some of Ontario's first responders. In this section, I briefly summarize the ministry's powers at the scene of an emergency response and, later in this Report, describe the extent to which these powers were known to those who participated in the response to the collapse of the Algo Mall.

### Why the Ministry of Labour may get involved in an emergency response

The Ministry of Labour is commonly notified of an emergency or a developing emergency at a workplace. This notification, as required under the *Occupational Health and Safety Act*,<sup>227</sup> typically comes through a variety of ways, such as direct contact from Emergency Management Ontario or from first responders, local governments, the media, or individuals reporting a worker fatality or critical injury. On notification of such an emergency, the ministry would, in the ordinary course, conduct a reactive inspection of a workplace involved in the emergency situation. It is important to note that ministry personnel typically conduct visits to the site of a workplace injury or fatality after a rescue or recovery of any victim.<sup>228</sup> Put another way, they do not usually arrive on the scene until the emergency response has ended.

## The applicability of the *Occupational Health and Safety Act* at the scene of an emergency response

There are instances, however, where the Ministry of Labour may attend at a scene while the emergency response is ongoing. Although the ministry is not directly involved in an emergency response, the *Occupational Health and Safety Act* nevertheless provides for minimum health and safety standards in *all* workplaces under provincial jurisdiction at all times, and the Act may be enforced by the ministry at any such workplace. This application includes a workplace at which an emergency response is under way. In short, the Act applies irrespective of whether the workplace in question is an emergency response and the workers are first responders. An emergency response scene is the workplace of the responders.<sup>229</sup>

The *Occupational Health and Safety Act* applies at all times to safeguard human life in emergency scenarios – even in a situation involving structural collapse and including work done by first responders. The Act has no provisions that exempt personnel involved in an emergency response, or their employers, from its general applicability.\* It applies whether the emergency response is a rescue or a recovery.

## The expected roles of Ministry of Labour personnel at an emergency response

In general terms, Ministry of Labour policy provides that its personnel perform dual roles in an emergency response: they can act in their usual capacity as the regulatory agency responsible for enforcing occupational health and safety standards as far as rescue workers are concerned, and they can provide technical support to those individuals in the emergency response.<sup>230</sup>

The *Occupational Health and Safety Act* empowers a ministry inspector to issue a “stop work” order in the event that there is a contravention of the Act which poses an imminent danger to the health or safety of a worker. In addition, the inspector may order that the contravention be remedied immediately for a specified period.<sup>231</sup> These powers can be enforced at a workplace where there is an ongoing emergency rescue or recovery.<sup>232</sup> The ministry expects that its personnel will exercise their legislated authority to enforce the *Occupational Health and Safety Act* with appropriate discretion, given the facts that may present themselves at a rescue scene.<sup>233</sup>

The Commission heard evidence that, at the time of the collapse of the Algo Mall, the Ministry of Labour did not have training, regulations, or policies in place that would assist its personnel in understanding rescue operations and how to exercise their statutory authority and discretion prudently at the scene of an emergency response. I will comment further on this issue later in the Report.

## Ontario Mine Rescue – a successful emergency response organization

Ontario Mine Rescue (OMR) is an organization that trains and supervises volunteers who respond to emergencies in approximately 40 underground mines in Ontario. It did not take part in the Elliot Lake response. However, I considered the evidence about it important because a number of individuals suggested that not only could OMR have helped but that its organization, training, and practices provide a valuable example of a successful emergency response organization from which lessons can be learned.

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\* Exhibit 9907. It should be noted that section 43(1)(2)(3) of the *Occupational Health and Safety Act* exempts first responders who have occupational responsibilities for the lives and safety of others from the right to refuse work.

OMR responds to two to three dozen emergencies a year.<sup>234</sup> Most are fires,<sup>235</sup> but others include rock bursts and underground collapses. This organization has been in existence since 1929. Formerly part of the Ministry of Labour, it is now part of Workplace Safety North (WSN),<sup>236</sup> an independent not-for-profit organization funded from Workplace Safety and Insurance Board premiums paid by the workplaces with which WSN deals. Effectively, the mines are paying for the cost of OMR.<sup>237</sup>

OMR was originally created as a result of a massive fire at the Hollinger Consolidated Gold Mine in Timmins in 1928 which resulted in the death of 39 mine workers.<sup>238</sup> At the time, Ontario did not have the capability to respond to such emergencies and, consequently, rescue teams from Pittsburgh, Pennsylvania, responded to the event. Justice T.E. Godson was appointed as the commissioner of a public inquiry into the disaster. He made a number of recommendations, including that persons be appointed to acquire and maintain rescue equipment and to train mine workers to respond to mine emergencies. That recommendation resulted in the formation of what eventually became Ontario Mine Rescue.<sup>239</sup> Subsequent serious incidents to which OMR responded led to further improvements in the way it operated, including province-wide mine rescue standards, better equipment, and expanding the firefighting role of OMR as well as its training and response to non-fire emergencies.<sup>240</sup>

OMR divides the province into eight regions, so that resources can be deployed effectively and efficiently. Each region is serviced by a mine rescue officer employed by OMR. These officers must have considerable mining experience, including supervisory positions, and have been involved for a minimum of seven years in mine rescue. The necessary equipment, owned by Workplace Safety North, is located in 34 mine rescue stations and substations found at every underground mine in Ontario.<sup>241</sup> The mine rescue officers are all trained in the use of the equipment, and they in turn provide training to volunteers, who are employed by the mines in the region.<sup>242</sup> They provide information during an emergency but not direction.<sup>243</sup>

The first responders in any mine emergency come from the approximately 875 mine rescue volunteers strategically distributed across the province.<sup>244</sup> They are called out to work for underground incidents only and are paid for their response work by the mines that employ them.<sup>245</sup>

## **Safety of responders is the first priority**

OMR has rigorous training and performance standards, which are set out in a compact portable handbook kept by the volunteers while on the job.<sup>246</sup>

The handbook lists the four main objectives of mine rescue and recovery work, in order of importance. They are listed as follows:

- To ensure the safety of mine rescue and recovery teams.
- To find trapped or missing miners and bring them to the surface.
- To respond to and resolve fire and non-fire emergencies.
- To examine the mine for dangerous concentrations of any noxious gases that would prevent normal operations in any part of the mine.<sup>247</sup>

When asked whether, as some have suggested, mine rescue workers would “walk into death’s door” to save the lives of workers trapped in a mine, Alex Gryska, the executive director of OMR, responded:

They will go a long ways. However, they will not put their people at risk. They will not. We have an incredible track record, and it is not by luck or chance; it is by design.



## **Extensive training and equipment, similar to that of HUSAR/TF3 and UCRT**

All volunteers must complete a competency-based five-day, 40-hour introductory training course and at least six eight-hour training sessions annually. They are trained in the use of equipment, including hydraulic spreaders typically used in extracting persons from automobiles, hydraulic splitters used to break rock, hydraulic bolt cutters, pneumatic bag-lifting systems used to prop up material to gain access, high-angle rescue and rappelling techniques to access trapped victims, and thermal-imaging cameras to locate missing persons. Shoring, with which miners are very familiar, is used in collapses along with jackhammers. Candidates must pass both a practical and a written exam with a mark of at least 70 percent. They must also pass periodic skill-based evaluations without any guidance or coaching. OMR provides advanced and technician training for experienced volunteers which involves further training and testing over at least two additional days every two years.<sup>248</sup>

Mr. Gryska testified that, at the Commission's request, he had asked Shawn Kirwan, OMR's emergency response specialist, to compare the training of the mine volunteers with that undergone by the members of HUSAR/TF3 and UCRT. Mine rescue volunteers are required to deal with collapses, both on the surface and underground, where large pieces of material have to be removed. They use the equipment I have described for cribbing and stabilization, among other things. While the mine rescue volunteers are trained to the awareness level or in some cases to the operations level for dealing with structural collapses, the HUSAR/TF3 and UCRT members are typically trained to the higher technician level. All mine volunteers are trained to the operations level and some to the technician level for rope rescues. Mine rescue team members are trained to the awareness level, and emergency response team members to the operations level, for confined space rescues.<sup>249</sup>

## **Response time: on site within 30 minutes**

OMR has performance standards for response time. The goal is for the first team to be on site in 30 minutes, and the second team in 45 minutes. The first team does not begin its mission until the second team is on site. By means of a mutual aid agreement, a third team will potentially be en route within an hour.<sup>250</sup> These timelines are devised to ensure as quick a response as possible because life is at stake. For each response, the time is recorded and, if the goals are not met, employers are advised that they need to take steps to improve their response times.<sup>251</sup>

OMR has learned from its own experience that, as a result of vacations, illness, or other reasons, not all volunteers are available when an emergency arises. It conducts frequent arbitrary "point in time" tests in which a mock call-out is conducted to determine the number of persons able to respond for each mine. OMR typically increases the required number of volunteers by 30 percent in order to ensure an adequate response.<sup>252</sup>

## **Chain of command**

### **One official in charge**

OMR has strict rules about the organization and procedure used during an emergency response. One person is designated as the "on-site official in charge," responsible for making critical decisions during the course of the emergency. Every mine has one such designated official, in advance of any emergency. Experience has taught OMR that this person must be someone with supervisory authority at the mine – somebody who knows the operation at that mine.<sup>253</sup>

## Support and information from the mine rescue officer and the emergency control group

A mine rescue officer is stationed at the mine during the rescue to serve as a consultant and to ensure that adequate equipment and supplies are available. That individual provides support and information, but not direction. Mine management is required to establish an “emergency control group” to provide advice. That group typically consists of experts such as structural engineers, ground control engineers, and hygienists.<sup>254</sup>

### Briefing officer as the liaison between the control group and the operations team

The briefing officer occupies an essential role in any OMR response. This person is the liaison between the control group and the team carrying out the underground operations and is responsible for maintaining communications with the working rescue team and the control room, following the team’s progress, and coordinating and overseeing the activities of all the personnel at the fresh-air base above ground, including the advisory committee. In addition, this person must obtain all the information about the site of the emergency, the type of emergency, the available equipment, the missing personnel, and the special skills required on the response team. Mr. Gyska testified that OMR had learned, over the 80 years of its existence, that having one individual responsible for communication between the control group and the team ensures good information flow. With one person being responsible, there is less room for error – plurality creates multiple opportunities for communication breakdown.<sup>255</sup>

### Team captain in charge of operations team

Each team of five volunteers carrying out operations in mine rescues is led by a “rescue team captain.” As the handbook states, he “shall take charge of, and be responsible for, the discipline, general safety and work performed by his team. He should take orders only from the briefing officer.” These team captains are experienced rescue volunteers who know the men and women on their team and understand each person’s abilities. Team captains take orders only from the briefing officer, because having a single conduit for communication minimizes opportunity for error.<sup>256</sup>

To summarize, mine rescues are organized in the following way: the volunteers work in teams; each team reports to a team captain, who reports to a briefing officer, who reports to the emergency control group, which, along with the mine rescue officer, provides advice to the official in charge – who has sole decision-making authority. There is a clear chain of command and communication.<sup>257</sup>

## Planning is absolutely critical

Mr. Gyska described the planning function in a rescue as “absolutely critical.” The safety of the rescuers is of paramount importance, and an effective plan is necessary before a mission is attempted. Urgency or lack of time is no reason not to plan. He testified:

[I]t will result in disaster if you don’t adequately plan. And certainly it is absolutely essential that you understand and anticipate the dangers, risks, and hazards that you will be exposing the teams to.<sup>258</sup>

## Briefing team members: in writing, with opportunity for questions

Briefing the members of the team about the task they are to carry out is an important part of the OMR system. The control group decides what the mission will be, and the briefing officer is the liaison with the team. The briefing is, if possible, to be carried out in a quiet room where the team members may ask questions and have the plan explained thoroughly without confusion or distraction. When asked why, he replied:

[I]mportant information is being exchanged, so obviously you want to ensure that there is clarity and understanding as to what the mission is going to be, clearly identifying to the teams where they need to go, what they need to do, and any distractions that might be in place could adversely affect their understanding of what needs to be done.<sup>259</sup>

Instructions to the team are required to be in writing. Mr. Gryska explained that the written instructions would typically be fairly brief. The requirement that they be in writing was to “reduce error obviously” and “so there is no misunderstanding as to what needs to be done.”<sup>260</sup>

Every briefing of a team should contain:

1. Information available
2. Persons missing, location and any trained persons
3. Action taken so far
4. Intention
5. Fresh air base location and standby teams
6. Communications
7. Installations such as air, water, electricity
8. Refuge stations
9. Route of travel
10. Conditions on route of travel
11. Ventilation
12. Visibility
13. Mine rescue equipment available
14. Firefighting equipment and hydrants
15. First aid equipment and stretcher
16. Tools and supplies
17. Time limit
18. Written instructions<sup>261</sup>

Mr. Gryska testified that in the organization’s experience, all these items are “absolutely critical elements that will affect the performance of the teams,” so they need to be addressed in the briefing. If not, there would be unacceptable potential for error.

## Written logs and reports required

The team captain is required to keep a log. The briefing officer is required to complete a detailed report setting out all the critical components of the mission, which is turned over to the control group. These documents are used to prepare a detailed report at the end of each mission.<sup>262</sup>



### Debriefings: essential and useful

A debriefing is held as soon after the incident as possible, but at most within a week. It is attended by the briefing officer, the team captain, the team members, the control group members, and persons from OMR or Workplace Safety. The debriefings can take several hours in some circumstances, depending on the number of issues encountered. Incident reports are produced and collected so that responses can be compared and improvements made. The debriefings are seen as a positive tool. They have resulted in changes in policies about how to conduct a response to a mine emergency.<sup>263</sup>

### OMR's experience: extensive and useful

A miner who is a victim of an incident in a mine has never been left underground in Ontario, although circumstances – such as the mine being sealed, for example – have required that miners be left underground in other places, as after the Westray mine collapse in Nova Scotia. Decisions made in responses to mine emergencies are always based first on the safety of the responding team.<sup>264</sup>

OMR has trained emergency responders in other countries. Mr. Gryska gave as an example the Caycli mine in Turkey, which is owned by a Canadian company. The owner asked OMR to train its workers to the Ontario standard. They did that, and in October 2011 the Turkish mine workers were asked to assist in rescuing victims caught in a five-storey student dormitory that had collapsed in an earthquake. Within 30 minutes, a team of 10 volunteers mobilized and drove 12 hours to the site of the collapse, successfully rescuing persons caught under the rubble.<sup>265</sup>

Mr. Gryska testified that the organization worked with HUSAR/TF3 during the collapse of a warehouse during a tornado in Goderich, Ontario.<sup>266</sup> OMR members from the Sifto Salt and Windsor Salt mines responded to the situation along with members from HUSAR/TF3, to remove a deceased individual.

OMR does not have an agreement with the Ontario government to provide assistance in emergencies occurring in places other than underground mines. It was not asked to help in Elliot Lake. It offered assistance in Elliot Lake, but its offers were ignored. Mr. Gryska testified that if it had been asked, it would have done so in co-operation with the engineers and other members of the HUSAR/TF3 and UCRT teams that were responding to the emergency. OMR would also have sent a mine rescue officer to assist in assessing the site. Mr. Gryska estimated that OMR would have been able to deploy a team of volunteers, with equipment in mine rescue vans, to assist in approximately two-and-a-half hours, given that the driving time from Sudbury, the mine location closest to Elliot Lake, is about two hours.<sup>267</sup>

## Notes

- <sup>1</sup> Hefkey testimony, August 8, 2013, pp. 20080–6.
- <sup>2</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 1.
- <sup>3</sup> Exhibit 5847–00001.
- <sup>4</sup> Exhibit 5847–00003.
- <sup>5</sup> Exhibit 5847–00003.
- <sup>6</sup> SO 1997, c 4, s 7.
- <sup>7</sup> Hefkey testimony, August 8, 2013, pp. 20092–3.
- <sup>8</sup> Exhibit 5847–00001.
- <sup>9</sup> Exhibit 5847–00002.
- <sup>10</sup> *Emergencies Act*, RSC 1985, c 22 (4th Supp.).
- <sup>11</sup> Exhibit 5847–00003.
- <sup>12</sup> Exhibit 5847–00002.
- <sup>13</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, ss 2.1 and 3.
- <sup>14</sup> Hefkey testimony, August 8, 2013, pp. 20143–4.
- <sup>15</sup> Hefkey testimony, August 8, 2013, pp. 20116–17.
- <sup>16</sup> Hefkey testimony, August 8, 2013, p. 20135.
- <sup>17</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 11(6).
- <sup>18</sup> Exhibit 5847–00004.
- <sup>19</sup> Hefkey testimony, August 8, 2013, pp. 20117–22.
- <sup>20</sup> Hefkey testimony, August 8, 2013, p. 20131.
- <sup>21</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 12(1)(4).
- <sup>22</sup> Hefkey testimony, August 9, 2013, p. 20418.
- <sup>23</sup> Hefkey testimony, August 8, 2013, pp. 20159–62.
- <sup>24</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 12(2)(3).
- <sup>25</sup> Hefkey testimony, August 8, 2013, pp. 20111–12 and August 9, 2013, p. 20421.
- <sup>26</sup> Exhibit 5847–00004.
- <sup>27</sup> Exhibit 5847–00004.
- <sup>28</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, ss 10–12.
- <sup>29</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 10(3).
- <sup>30</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 11(5)(6).
- <sup>31</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 4.
- <sup>32</sup> Hefkey testimony, August 8, 2013, pp. 20188–9.
- <sup>33</sup> Exhibit 5847–00002.
- <sup>34</sup> Exhibit 5847–00004.
- <sup>35</sup> Hefkey testimony, August 8, 2013, p. 20193; Exhibit 5847–00004.
- <sup>36</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, s 13(1).
- <sup>37</sup> Exhibit 5847–00001.
- <sup>38</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, ss 13(1) and 14.
- <sup>39</sup> Hefkey testimony, August 8, 2013, p. 20155.
- <sup>40</sup> Exhibit 5847–00001.
- <sup>41</sup> *Fire Protection and Prevention Act*, SO 1997, c 4, s 7.
- <sup>42</sup> Exhibit 5847.
- <sup>43</sup> Hefkey testimony, August 8, 2013, pp. 20097–100.
- <sup>44</sup> *Fire Protection and Prevention Act*, SO 1997, c 4, ss 2 and 5.
- <sup>45</sup> Exhibit 5847–00001.
- <sup>46</sup> Exhibit 5847–00001.
- <sup>47</sup> *Emergency Management and Civil Protection Act*, O Reg 380/04, ss 1–5.
- <sup>48</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 7.0.1(1).
- <sup>49</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 7.03(2).
- <sup>50</sup> Exhibit 5847–00002.
- <sup>51</sup> Exhibit 5847–00002.
- <sup>52</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 7.0.1.
- <sup>53</sup> Ministry of Community Safety and Correctional Services, News Release, “Building Safer Communities: Ontario Combining Emergency Management Ontario, Office of the Fire Marshal” (August, 15, 2013), online: <http://news.ontario.ca/mcscs/en/2013/08/building-safer-communities.html>.
- <sup>54</sup> Exhibit 5847–00003.
- <sup>55</sup> Exhibit 5847–00001.
- <sup>56</sup> Exhibit 5847–00001.
- <sup>57</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 8.
- <sup>58</sup> Hefkey testimony, August 8, 2013, pp. 20166–9 and 20178–9; Exhibit 5847–00004.
- <sup>59</sup> Exhibit 5847–00003.
- <sup>60</sup> Exhibit 5847–00003.
- <sup>61</sup> Exhibit 5847–00003.
- <sup>62</sup> Exhibit 5847–00004.
- <sup>63</sup> Exhibit 5847–00003.
- <sup>64</sup> Exhibit 7847.
- <sup>65</sup> Hefkey testimony, August 8, 2013, 2013, pp. 20213–14.
- <sup>66</sup> Hefkey testimony, August 8, 2013, 2013, pp. 20216–24.
- <sup>67</sup> Exhibit 5847–00003.
- <sup>68</sup> Hefkey testimony, August 8, 2013, p. 20239.
- <sup>69</sup> Exhibit 5847–00002.
- <sup>70</sup> Exhibit 5847–00001.
- <sup>71</sup> Exhibit 5847–00004.
- <sup>72</sup> Hefkey testimony, August 9, 2013, pp. 20345–9.
- <sup>73</sup> Exhibit 5847–00004.
- <sup>74</sup> Exhibit 5847–00001.
- <sup>75</sup> Exhibit 5847–00003.
- <sup>76</sup> Exhibit 5847–00004.
- <sup>77</sup> Hefkey testimony, August 8, 2013, pp. 20126–8.
- <sup>78</sup> Exhibit 5847–00001.
- <sup>79</sup> Exhibit 5847–00004.
- <sup>80</sup> Exhibit 5847–00004.
- <sup>81</sup> *Fire Protection and Prevention Act*, SO 1997, c 4, s 7.
- <sup>82</sup> Chambers testimony, September 18, 2013, pp. 26068–70.
- <sup>83</sup> Chambers testimony, September 18, 2013, pp. 26068–70.
- <sup>84</sup> Chambers testimony, September 18, 2013, pp. 26074–6.
- <sup>85</sup> Exhibit 5847–00005.
- <sup>86</sup> Exhibit 5847–00003.
- <sup>87</sup> Exhibit 5847–00002.
- <sup>88</sup> Hefkey testimony, August 8, 2013, p. 20221.
- <sup>89</sup> Hefkey testimony, August 9, 2013, pp. 20466–9.
- <sup>90</sup> Exhibit 5847–00004.
- <sup>91</sup> Exhibit 5847–00004.
- <sup>92</sup> Exhibit 5847–00003.
- <sup>93</sup> Exhibit 8006.

- <sup>94</sup> Hefkey testimony, August 8, 2013, p. 20241.
- <sup>95</sup> Hefkey testimony, August 8, 2013, p. 20245.
- <sup>96</sup> Hefkey testimony, August 8, 2013, pp. 20244–6.
- <sup>97</sup> Exhibit 887, p. 20.
- <sup>98</sup> Chambers testimony, September 18, 2013, pp. 26226–7.
- <sup>99</sup> Exhibit 8006, p. 2.
- <sup>100</sup> Exhibit 887, p. 22.
- <sup>101</sup> Exhibit 887, p. 12.
- <sup>102</sup> Hefkey testimony, August 8, 2013, pp. 20249–50.
- <sup>103</sup> Exhibit 887, p. 12.
- <sup>104</sup> Exhibit 887, pp. 20–21.
- <sup>105</sup> Exhibit 8006, p. 2.
- <sup>106</sup> Exhibit 887, p. 31.
- <sup>107</sup> Exhibit 887, p. 46.
- <sup>108</sup> Exhibit 887, p. 47.
- <sup>109</sup> Exhibit 887, p. 47.
- <sup>110</sup> Exhibit 8006, p. 3.
- <sup>111</sup> Exhibit 8006, p. 3.
- <sup>112</sup> Exhibit 887, pp. 52–3.
- <sup>113</sup> Exhibit 887, pp. 32–3; Hefkey testimony, August 8, 2013, pp. 20266–8.
- <sup>114</sup> Exhibit 887, p. 36.
- <sup>115</sup> Exhibit 887, p. 36.
- <sup>116</sup> Exhibit 887, p. 40.
- <sup>117</sup> Exhibit 8006, p. 3.
- <sup>118</sup> Exhibit 887, p. 54.
- <sup>119</sup> Exhibit 887, p. 54.
- <sup>120</sup> Exhibit 887, p. 55.
- <sup>121</sup> Exhibit 8006, p. 5.
- <sup>122</sup> Exhibit 887, p. 55.
- <sup>123</sup> Exhibit 8006, pp. 6–7.
- <sup>124</sup> Exhibit 7842, p. 8; Hefkey testimony, August 9, 2013, pp. 20298–303.
- <sup>125</sup> Hefkey testimony, August 9, 2013, p. 20304.
- <sup>126</sup> Exhibit 7842, p. 8; Hefkey testimony, August 9, 2013, pp. 20305–6.
- <sup>127</sup> Exhibit 7842, p. 8; Hefkey testimony, August 9, 2013, pp. 20306–9.
- <sup>128</sup> Hefkey testimony, August 9, 2013, pp. 20310–11.
- <sup>129</sup> Hefkey Testimony, August 9, 2013, pp. 20455–6.
- <sup>130</sup> Officer testimony, August 21, 2013, pp. 21519–20.
- <sup>131</sup> Thomas testimony, August 15, 2013, p. 20982.
- <sup>132</sup> Officer testimony, August 29, 2013, pp. 23350–4.
- <sup>133</sup> Officer testimony, August 22, 2013, pp. 21881–4.
- <sup>134</sup> Officer testimony, August 29, 2013, pp. 23356–60.
- <sup>135</sup> Officer testimony, August 21, 2013, pp. 21512–16.
- <sup>136</sup> Officer testimony, August 21, 2013, pp. 21517–18.
- <sup>137</sup> Officer testimony, August 20, 2013, pp. 21518–20.
- <sup>138</sup> Officer testimony, August 21, 2013, pp. 21524–5.
- <sup>139</sup> Exhibit 8053.
- <sup>140</sup> Exhibit 9673.
- <sup>141</sup> Rheume testimony, September 26, 2013, p. 27479.
- <sup>142</sup> Exhibit 8090.
- <sup>143</sup> Rheume testimony, September 26, 2013, pp. 27484–5.
- <sup>144</sup> Exhibit 8090.
- <sup>145</sup> Exhibit 8090.
- <sup>146</sup> Exhibit 8087.
- <sup>147</sup> Exhibit 8090.
- <sup>148</sup> Exhibit 8090.
- <sup>149</sup> Exhibit 8087.
- <sup>150</sup> Exhibit 8087.
- <sup>151</sup> Exhibit 8090.
- <sup>152</sup> Exhibit 8090.
- <sup>153</sup> Exhibit 8090.
- <sup>154</sup> Exhibit 8090.
- <sup>155</sup> Exhibit 8087.
- <sup>156</sup> Exhibit 8090.
- <sup>157</sup> Exhibit 8087.
- <sup>158</sup> Comella testimony, September 4, 2013, p. 23901.
- <sup>159</sup> Exhibit 5847–00009.
- <sup>160</sup> Exhibit 9278.
- <sup>161</sup> Exhibit 9278.
- <sup>162</sup> Comella testimony, September 4, 2013, p. 23896.
- <sup>163</sup> Comella testimony, September 4, 2013, p. 23987.
- <sup>164</sup> Exhibit 9278.
- <sup>165</sup> Comella testimony, September 4, 2013, pp. 23987–9.
- <sup>166</sup> Exhibit 9278.
- <sup>167</sup> Hefkey testimony, August 8, 2013, p. 20219.
- <sup>168</sup> Exhibit 768.
- <sup>169</sup> Unless otherwise noted, all references for these milestones are to be found Exhibit 9278.
- <sup>170</sup> Comella testimony, September 4, 2013, p. 23988.
- <sup>171</sup> Comella testimony, September 4, 2013, p. 23989.
- <sup>172</sup> Comella testimony, September 4, 2013, pp. 23989–90.
- <sup>173</sup> Comella testimony, September 6, 2013, pp. 24418–20.
- <sup>174</sup> Comella testimony, September 4, 2013, pp. 23905–8.
- <sup>175</sup> Exhibit 245.
- <sup>176</sup> Comella testimony, September 4, 2013, p. 23953.
- <sup>177</sup> Comella testimony, September 4, 2013, p. 23929.
- <sup>178</sup> Comella testimony, September 4, 2013, pp. 23932–3.
- <sup>179</sup> Exhibit 9278.
- <sup>180</sup> Comella testimony, September 4, 2013, pp. 23938–9.
- <sup>181</sup> Exhibit 7834.
- <sup>182</sup> Comella testimony, September 4, 2013, pp. 23940–2.
- <sup>183</sup> Exhibit 7834.
- <sup>184</sup> Exhibit 9278.
- <sup>185</sup> Comella testimony, September 4, 2013, pp. 23944–5.
- <sup>186</sup> Comella testimony, September 4, 2013, pp. 23962–4.
- <sup>187</sup> Comella testimony, September 4, 2013, p. 23961.
- <sup>188</sup> Comella testimony, September 4, 2013, p. 23962; Exhibit 9278.
- <sup>189</sup> Exhibit 9278.
- <sup>190</sup> Comella testimony, September 4, 2013, pp. 23965–8.
- <sup>191</sup> Comella testimony, September 4, 2013, p. 23971.
- <sup>192</sup> Comella testimony, September 4, 2013, pp. 23971–2.
- <sup>193</sup> Comella testimony, September 4, 2013, p. 24003–4.
- <sup>194</sup> Comella testimony, September 4, 2013, p. 23974.
- <sup>195</sup> Comella testimony, September 4, 2013, p. 23985.
- <sup>196</sup> Needles testimony, September 10, 2013, pp. 25198–9.
- <sup>197</sup> Exhibit 9278.
- <sup>198</sup> Needles testimony, September 10, 2013, pp. 25245–6.
- <sup>199</sup> Comella testimony, September 4, 2013, pp. 23914–16.
- <sup>200</sup> Exhibit 9278.
- <sup>201</sup> Comella testimony, September 4, 2013, p. 23922.
- <sup>202</sup> Comella testimony, September 4, 2013, pp. 24060–70.
- <sup>203</sup> Comella testimony, September 4, 2013, pp. 24070–6.
- <sup>204</sup> Comella testimony, September 4, 2013, p. 23918.
- <sup>205</sup> Comella testimony, September 4, 2013, p. 24019.
- <sup>206</sup> Needles testimony, September 10, 2013, p. 25203.
- <sup>207</sup> Comella testimony, September 4, 2013, p. 23918.
- <sup>208</sup> Comella testimony, September 4, 2013, pp. 24010–12.



- <sup>209</sup> Exhibit 7847.
- <sup>210</sup> Bruce testimony, August 23, 2013, pp. 22114–15.
- <sup>211</sup> Waddick testimony, August 23, 2013, pp. 21967–8.
- <sup>212</sup> Exhibit 7844.
- <sup>213</sup> Gillespie testimony, September 3, 2013, pp. 23459–62.
- <sup>214</sup> Gillespie testimony, September 3, 2013, pp. 23509–10.
- <sup>215</sup> Gillespie testimony, September 3, 2013, p. 23463.
- <sup>216</sup> Exhibit 7844.
- <sup>217</sup> Cox testimony, August 26, 2013, pp. 22207–8.
- <sup>218</sup> Gillespie testimony, September 3, 2013, p. 23467; Exhibit 7850.
- <sup>219</sup> Gillespie testimony, September 3, 2013, pp. 23473–9.
- <sup>220</sup> Gillespie testimony, September 4, 2013, pp. 23809–10.
- <sup>221</sup> Gillespie testimony, September 3, 2013, pp. 23518–19.
- <sup>222</sup> Bruce testimony, August 23, 2013, pp. 22173–5.
- <sup>223</sup> Exhibit 7844.
- <sup>224</sup> Exhibit 7844.
- <sup>225</sup> Exhibit 7844.
- <sup>226</sup> Exhibit 7805.
- <sup>227</sup> Exhibit 9907.
- <sup>228</sup> Exhibit 9907.
- <sup>229</sup> Exhibit 9907.
- <sup>230</sup> Exhibit 9907.
- <sup>231</sup> *Occupational Health and Safety Act*, RSO 1990 c 0.1, s 57(1).
- <sup>232</sup> Exhibit 9907.
- <sup>233</sup> Exhibit 9907, referencing the Ministry of Labour Emergency Response Plan.
- <sup>234</sup> Gyska testimony, September 23, 2013, p. 26680.
- <sup>235</sup> Gyska testimony, September 23, 2013, p. 26681.
- <sup>236</sup> Gyska testimony, September 23, 2013, p. 26618.
- <sup>237</sup> Gyska testimony, September 23, 2013, p. 26619.
- <sup>238</sup> Gyska testimony, September 23, 2013, p. 26620.
- <sup>239</sup> Gyska testimony, September 23, 2013, pp. 26620–26621; for a copy of Commission Report, see [https://openlibrary.org/works/OL16279844W/In\\_the\\_matter\\_of\\_a\\_fire\\_that\\_occurred\\_in\\_the\\_Hollinger\\_Consolidated\\_Gold\\_Mines\\_Limited\\_and\\_in\\_the\\_ma](https://openlibrary.org/works/OL16279844W/In_the_matter_of_a_fire_that_occurred_in_the_Hollinger_Consolidated_Gold_Mines_Limited_and_in_the_ma).
- <sup>240</sup> Gyska testimony, September 23, 2013, pp. 26621–2.
- <sup>241</sup> Gyska testimony, September 23, 2013, pp. 26623–5, and 26685–7.
- <sup>242</sup> Gyska testimony, September 23, 2013, p. 26659.
- <sup>243</sup> Gyska testimony, September 23, 2013, p. 26659–60.
- <sup>244</sup> Gyska testimony, September 23, 2013, pp. 26625–6.
- <sup>245</sup> Gyska testimony, September 23, 2013, p. 26625.
- <sup>246</sup> Gyska testimony, September 23, 2013, p. 26627; Exhibit 5847–11.
- <sup>247</sup> Gyska testimony, September 23, 2013, pp. 26668–9; Exhibit 5847–11, p. 00182.
- <sup>248</sup> Gyska testimony, September 23, 2013, pp. 26628–34, 26638, and 26642–5; Exhibit 58347–11, pp. 059–63, 142, 145, 149, 151, 153, 161, 172; Exhibit 9694, p. 002.
- <sup>249</sup> Gyska testimony, September 23, 2013, pp. 26647–53; Exhibit 9750.
- <sup>250</sup> Gyska testimony, September 23, 2013, p. 26684.
- <sup>251</sup> Gyska testimony, September 23, 2013, p. 26685.
- <sup>252</sup> Gyska testimony, September 23, 2013, pp. 26654–6; Exhibit 5847–11, pp. 0040–1.
- <sup>253</sup> Gyska testimony, September 23, 2013, pp. 26656–8; Exhibit 5847–11, p. 0045.
- <sup>254</sup> Gyska testimony, September 23, 2013, pp. 26659–60; Exhibit 5847–11, pp. 0037 and 00187.
- <sup>255</sup> Gyska testimony, September 23, 2013, pp. 26661–4; Exhibit 5847–11, pp. 00189–90.
- <sup>256</sup> Gyska testimony, September 23, 2013, pp. 26664–5; Exhibit 5847–11, pp. 0193–4.
- <sup>257</sup> Gyska testimony, September 23, 2013, p. 26666.
- <sup>258</sup> Gyska testimony, September 23, 2013, p. 26667.
- <sup>259</sup> Gyska testimony, September 23, 2013, pp. 26671–2; Exhibit 5847–11, p. 0188.
- <sup>260</sup> Gyska testimony, September 23, 2013, pp. 26672–3.
- <sup>261</sup> Exhibit 5847–11, p. 0189–92.
- <sup>262</sup> Gyska testimony, September 23, 2013, pp. 26674–5; Exhibit 5847–11, p. 0192.
- <sup>263</sup> Gyska testimony, September 23, 2013, pp. 26675–7.
- <sup>264</sup> Gyska testimony, September 23, 2013, p. 26683.
- <sup>265</sup> Gyska testimony, September 23, 2013, pp. 26689–90; Exhibit 9702.
- <sup>266</sup> Gyska testimony, September 23, 2013, p. 26677.
- <sup>267</sup> Gyska testimony, September 23, 2013, pp. 26695–8.

# First Responders and Deployments of Various Teams (Collapse to 11 p.m. on June 23)

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## The collapse

### The Mall collapses at 2:18 p.m.

The Algo Centre rooftop collapsed on June 23, 2012, at 2:18 p.m. The collapse was captured in part by surveillance cameras, and the videos were screened during the Commission's hearings.<sup>1</sup> Owing to their graphic nature, I issued a warning to the public before they were shown. In one, shortly after the passage of a vehicle going one way and two pedestrians walking in the opposite direction, the deck gives way and a parked vehicle suddenly drops into the Mall. Another shows Mrs. Doloris Perizzolo and Ms. Lucie Aylwin at the lottery kiosk a second or two before the roof crashed down on them. The collapse was abrupt, precipitous, and without any forewarning.

Several calls were made to the authorities to report the collapse. One of the first came from an employee from Dollarama, who informed the dispatcher at the Elliot Lake Fire Department that the roof had collapsed and that she could not assess the situation beyond what she saw in her immediate area. She then handed the phone over to a man, who described the collapsed zone as consisting of the area on the rooftop parking deck extending from the doors of the Hotel offices to the doors of the structure over the escalators and the staircase leading into the Mall, also referred to as "the penthouse." He could not tell whether anyone had been hurt but stated that everyone from the food court had been evacuated:

*Operator:* Is anybody hurt, that you know of?

*Man:* I can't tell. Everybody that was in the food court is now mostly evacuated out. I think there might have been a few people in that area and there's a few people that [look] like they're helping.

*Operator:* Ok, we'll have everybody respond. We'll be there shortly.<sup>2</sup>



**Figure 2.3.1** The collapse zone

Source Exhibit 7924

## Accounts from eyewitnesses

To avoid unnecessary repetition, Commission counsel called only a representative sampling of the important eyewitnesses to testify at the hearings.

### Jason Morrissey

Jason Morrissey arrived at the Mall with his wife, Sherri Watson, at 2:10 p.m. They parked on the roof and entered the Mall through the doors of the penthouse. Mr. Morrissey confirmed that he and his wife were the two individuals seen on the surveillance video walking on the rooftop parking into the penthouse seconds before the roof collapsed.<sup>3</sup> They walked halfway down the stairs to a landing. From there, Mr. Morrissey described the scene:

She was about two steps ahead of me. As soon as it shook, I ... grabbed her by the neck, by the back of the shirt ... and I yanked her back. And as I was yanking her back, it came down, grazed her head, grazed her leg, and that's it.<sup>4</sup>

Mr. Morrissey testified that concrete slabs, drywall, and glass came down in front of them. His wife was hit on the head and on the left leg, which was covered in blood by the time he pulled her back. He wrapped her leg with his shirt. He was not hit at all. He and his wife then ran outside, through the doors on the west side of the penthouse. They had to be careful as they exited through the doors because the chasm from the collapse was there. They took a quick left and walked over part of a slab in order to get on a solid part of the rooftop parking.<sup>5</sup>

Once outside, Mr. Morrissey saw children at the Hotel office doors in front of the area where the elevators of the Hotel were located. These doors were on the perimeter of the collapsed section. He told them to stay back.<sup>6</sup> Mr. Morrissey got close to the gaping hole and looked down. He testified the view below was "[a] mess" and he saw people only at the food court one level below. He heard screaming but could not determine where it came from: "It was just all coming up at one time."<sup>7</sup>

Mr. Morrissey was on the roof for five to 10 minutes, after which he drove off to the hospital with his wife. She was attended to right away. She had flesh wounds, including a deep cut, but did not require stitches.<sup>8</sup>



**Figure 2.3.2 Staircase with debris: looking into the collapse area**

Source Exhibit 7924



**Figure 2.3.3 Doors at the top of the staircase of the parking level**

Source Exhibit 7924



## Jean-Marie Marceau

Jean-Marie Marceau is an 80-year-old retired miner.<sup>9</sup> He uses an oxygen tank, which he had left in his truck when he went to the Mall.<sup>10</sup> He entered the Mall through the main entrance on the south side at 2:10 p.m. and took the elevator to the food court on the second floor, where he was supposed to meet a friend. His friend was not there,

**When he placed his coffee on the table, Mr. Marceau heard a big bang and was hit by debris on the head, over the eyes, and on the nose. He lost consciousness immediately.**

but another friend who was there offered to buy him a coffee. When he placed his coffee on the table, Mr. Marceau heard a big bang and was hit by debris on the head, over the eyes, and on the nose. He lost consciousness immediately.<sup>11</sup>

Mr. Marceau had been standing close to the kiosk when the roof collapsed. Before he heard the noise from the collapse, he heard people yell. He does not know how long he remained unconscious. When he regained consciousness he was alone, and he checked to see if he had any broken bones. He crawled a few feet, although he felt pain on the left side of his ribs. He was surrounded by dust and debris. He managed to get up eventually and walked up to Ms. Judy LaFleur, who was at the exit door. She helped him walk, and then

another person took over assisting him.<sup>12</sup> After sitting down for a few minutes to take a break, Mr. Marceau went to exit the Mall at the ramp where Zellers was located.<sup>13</sup>

Once outside, Mr. Marceau was attended to by a paramedic. He informed the paramedic that he needed oxygen, and he was told that others might need it more than he did. He eventually walked by himself to his truck, where his oxygen tank was located. He returned to the ambulance when his breathing had stabilized, and he was taken to the hospital about 45 minutes to one hour later.<sup>14</sup> Mr. Marceau was treated for cuts and a broken rib. He was released the same day, but he received follow-up care the next day.<sup>15</sup>

## Yves Bérubé

I also heard from Yves Bérubé, the owner of Creations and Things in the Mall. His store was adjacent to the north end of the collapse zone,<sup>16</sup> and its front was demolished by the collapse.<sup>17</sup> Mr. Bérubé had closed his store temporarily so he could have a cigarette break. On his way out of the Mall, he saw Ms. Aylwin working at the kiosk. When the collapse occurred he was standing outside, on the walkway located on the second level. The cigarette, it would appear, had taken him out of harm's way.<sup>18</sup> As he was about to light it, he heard a loud noise behind him. All the doors leading to the walkway blew open and a cloud of dust flew out.<sup>19</sup>

I immediately ran right back in. And as I got through those doors, I looked up and I was seeing sky, which wasn't right. And directly in front of me was the escalator going downstairs to the lower mall, that basically was all collapsed down there, all rubble and whatnot. There was ... basically dust clouds and water blasting everywhere and ... a few people frantically trying to get out ...<sup>20</sup>

He also saw Mr. Marceau sitting in a chair as well as an elderly woman who was surrounded by large pieces of concrete. Both of them seemed to be all right, so he walked around the area and noticed Ms. LaFleur and three other individuals who were helping other people:

The first person I came across actually was Mr. Marceau ... He was actually at that time sitting in a chair with his head in his hands, covered in blood. I quickly just kind of checked him out to see if he was okay ... just a few feet away from Mr. Marceau, there was another elderly lady sitting in a chair. And I remember that there [were] large pieces of concrete and steel and whatnot virtually all around her, but nothing on her. That was kind of shocking.<sup>21</sup>



**Figure 2.3.4 Second-level concourse facing north toward the kiosk area**

Source Exhibit 7924

Mr. Bérubé was not injured or struck by any debris. He described the collapse as being instantaneous and without warning.<sup>22</sup> Ms. LaFleur eventually called him to help get Mr. Marceau out of the Mall. They proceeded, with Mr. Marceau, toward the same doors he had walked through earlier. Mr. Bérubé saw through the rail of the walkway that firefighters and police had gathered at the scene, and he sought their help. He re-entered the Mall to see if there was anyone else inside, and he noticed a young lady on the rubble pile, calling out to ask whether anyone was there. He told her to leave the Mall "because it may not be done yet."<sup>23</sup> He described pipes bursting and water blasting everywhere. He was not sure whether the building would crumble further.<sup>24</sup> At that time, he remembers only Ms. LaFleur, the three other individuals, and himself being present in the food court area.<sup>25</sup>

**He described pipes bursting and water blasting everywhere. He was not sure whether the building would crumble further.**

When they concluded that no one else needed help, they went onto the walkway. Mr. Bérubé first saw Danny Kluge, a firefighter, standing on the ground below him. When he informed him that no one else was in the Mall, Mr. Kluge told him to get down out of the Mall himself. He immediately descended the stairs at the east end of the walkway.<sup>26</sup>

When he reached the lower level, he did not see anyone being taken away by the ambulance. Everyone gathered in front of the main entrance to the Mall. He called his wife, and his mother-in-law came to drive him home.<sup>27</sup>

## Adam Amyotte

Adam Amyotte was working at the Bargain Shop in the Mall that day. He was walking through the Mall when he passed by Mrs. Perizzolo, who was standing at the lottery kiosk.<sup>28</sup> He was 150 feet from the kiosk when the roof

**"[E]verything happened so fast. As it happened it sounded like pipes falling ... and everything was gone ... I don't know how else to explain it."**

**– Adam Amyotte**

collapsed. He did not hear anything before the collapse but testified that, when it occurred, it sounded as though pipes were falling: "[E]verything happened so fast. As it happened it sounded like pipes falling ... and everything was gone ... I don't know how else to explain it."<sup>29</sup>

Mr. Amyotte was not hit by debris, and he helped a few nearby individuals to get back on their feet. He described the scene on the second floor as "organized chaos": the people who were there helped each other and worked as a team.<sup>30</sup> Among those helping were staff from various businesses who directed people out the emergency exits. Mr. Amyotte testified that this process lasted mere minutes, although "it felt like hours."<sup>31</sup>

Once everyone had exited, Mr. Amyotte and others went to the parking lot in front of the Foodland store, where he remained for 45 minutes.<sup>32</sup>

## Accounts from victims' families

### Doloris Perizzolo's family

Teresa Perizzolo, the daughter of Doloris Perizzolo, was scheduled to work at the Bargain Shop the day of the collapse, but she informed her manager she would not be able to do so. She first heard about the collapse at 2:30 p.m., when she received a call from a friend who was worried that she may have been working at the Mall. She testified that she was not surprised to hear about the collapse because she recalls that, during the eight years she worked at the Mall, wet ceiling tiles had frequently fallen to the floor: "[T]hey called it cave-ins, which meant the ceiling tiles dropped down ... not slabs as big as the one that fell, but pieces of concrete would fall, and it was on a daily basis."<sup>33</sup>

Ms. Perizzolo first believed her mother was in the Mall when she drove there and saw her mother's van parked out front:

I ... drove down to where my mother got her hair done at 11:30 that morning, which was down at the lower plaza, and when I asked the lady if my Mom had gotten her hair done, she said 'Yes, why?' and I said, 'I just want to know where she is,' because I had [driven] by the house and ... she wasn't at home. And then panic [struck] on the lady's face, she started crying, and we walked up to the Mall and that's when I [saw] her van in front of the Mall.<sup>34</sup>

Ms. Perizzolo saw many people crying and three ambulances in front of the Mall. She called her husband, Darrin Latulippe, and he went to the scene. An officer told him where he would find his wife. In the meantime, Ms. Perizzolo asked the paramedics where she could get more information, and she was told to call the hospital every five minutes to check whether her mother had been admitted. Shortly thereafter, Ms. Perizzolo and the other people who were standing in the area were evacuated because of fear of a gas leak. She stayed on site for another 20 to 25 minutes, waiting to get more information.<sup>35</sup>

At 4:00 p.m., Ms. Perizzolo and Mr. Latulippe went to the Collins Hall, which had been set up as a "command post" for family members of missing individuals.<sup>36</sup>



## Lucie Aylwin's family

Lucie Aylwin was employed at the Mall on the day of the collapse. She took a job at the lottery kiosk when the employees of her main employer, Boreal College, went on strike. Rachelle Aylwin, her mother, was unaware that her daughter was working that day because she was supposed to attend an event with her fiancé, Gary Gendron. Mrs. Aylwin found out about the collapse at 2:30 p.m. or 2:45 p.m., when she listened to voicemails on her phone from her daughter's friend, Adrena White, and from Mr. Gendron.<sup>37</sup>

I looked at my telephone. I saw that Adrena ... White, one of her best [friends] and Gary had called. So, I listened to the messages and I heard Adrena. She was crying ... She said 'Call me back.' The second message was from Gary telling me 'Call me. It's very important. Something happened to Lucie.'<sup>38</sup>

When Réjean Aylwin, Ms. Aylwin's father, returned the call to Ms. White at 3:00 p.m.; she explained what had happened at the Mall. At 3:30 p.m., Mr. and Mrs. Aylwin left their home in Sudbury to drive to Elliot Lake. They also informed their daughter-in-law in Alberta of the situation and asked that their son come to join them.<sup>39</sup>

Mr. Gendron was in Sault Ste. Marie on the afternoon of June 23, 2012. His phone rang at 2:30 p.m. or 2:45 p.m., and he found Ms. White on the line. She told him that the Mall had collapsed and that she thought Ms. Aylwin was inside:

[S]he was yelling and screaming and saying that the Mall had collapsed and I said, 'I've got a two-hour drive here, you know, like slow down. I'd like to – what's going on?' So she said, 'Well, they think Lucie is stuck in the collapse.'<sup>40</sup>

Mr. Gendron had last communicated with Ms. Aylwin by text message at 12:01 p.m. After the call, he briefly stopped by a friend's house before heading to Elliot Lake.<sup>41</sup>

At approximately 4:00 p.m., Mr. Gendron arrived in Elliot Lake. He went straight to the OPP station, even though "everybody" was telling him to go to the Collins Hall. At the station, he spoke with a police officer, who told him they were not sure where the collapse had occurred but they believed Ms. Aylwin was in the rubble. He proceeded to the Collins Hall, where he met up with Mr. and Mrs. Aylwin.<sup>42</sup>

He described the scene at the Collins Hall as chaotic: the number of missing individuals was not known at the time. He recalled that 40 to 50 people were there. About 24 hours after the collapse, the authorities narrowed the list of missing to two individuals.<sup>43</sup>

Mr. and Mrs. Aylwin arrived in Elliot Lake at 5:00 p.m. They first drove to Shoppers Drug Mart because Ms. White was there. When they approached the Mall, Mr. Aylwin spoke to a police officer, who told them to go to the Collins Hall. He and his wife went to the hall, where they introduced themselves to another police officer and were assisted by the Red Cross and another organization.<sup>44</sup>

## Injuries to individuals present at the Mall

A review of the medical records produced to the Commission by the St. Joseph's General Hospital reveals that 18 individuals were treated at the hospital as a result of the collapse. The injuries sustained by these individuals, as well as their symptoms, included, nausea and vomiting as a result of being hit on the head, shoulders, and neck with debris; headaches; dry eyes; decreased range of motion in the neck and back; rib fractures; dislocation of a lumbar vertebra; lacerations to the eyebrow and the ecchymosis under the eye; chest wall injury; laceration, abrasions, and contusions to the limbs and face; tenderness in the knees; sprained ankle; sinus tachycardia (elevated heart rate); mild trauma; anxiety; and post-traumatic stress disorder.<sup>45</sup> Considering the nature of the collapse and the fate of Mrs. Perizzolo and Ms. Aylwin, these individuals were fortunate not to have sustained more serious physical injuries.

## First responders on the scene

### 2:29 p.m.: The Elliot Lake Fire Department arrives on the scene and shuts off the utilities

Capt. John Thomas of the Elliot Lake Fire Department arrived on the scene at 2:29 p.m. He was not on duty at the time, and he explained that when he responds to a call while off duty, he responds as a firefighter, not as a captain. Another fire truck, which had been brought to the scene by Capt. David George and firefighter Danny Kluge, was already there when he arrived. Capt. George was the incident commander at that point because he was the most senior person on shift at the time of the call.<sup>46</sup>

Once he arrived, Capt. Thomas reported to the incident commander and asked him for instructions. He put on his self-contained breathing apparatus as directed, and then he was told to shut off the gas coming into the building while others were ordered to shut off the water and the hydro.<sup>47</sup>

Chief Paul Officer arrived on the scene at 2:30 p.m. and received an update from the incident commander.<sup>48</sup> His notes, prepared after the event and based on Fire Department radio communications, indicate at 2:31 p.m.:

The Incident Commander (IC) gave me a quick update.

The scene was a 2 storey mall L shaped with car park on the roof. It also has a 3 storey hotel starting above the mall roof level attached on the north side. The building is constructed on non combustible material with a sprinkler system and fire alarm system. The structure was built with structural steel, core slab with a concrete topping.

The command was set up at the mall front doors. The update from the IC was that the crews were already instructed to shut off all utilities. Looking in the main doors [of] the collapse zone I could see a large amount of water pouring into the zone, electrical cables hanging and a large steel beam hanging.<sup>49</sup>

Although he was not on duty at the time of the call, Chief Officer was able to make his way to the Mall directly from home because he carries the protective clothing for firefighters in the back of his car.<sup>50</sup> He assumed the role of incident commander shortly after he arrived. At that point, the firefighters could not see any injured persons on the scene. He also described the approximate area of the collapse. No fire personnel had entered the building at that time.<sup>51</sup>

Chief Officer's notes indicate that Bruce Ewald, the City's chief building official, arrived at 2:45 p.m.<sup>52</sup> He asked Mr. Ewald, who had experience with steel and precast concrete, to do a quick assessment of the collapse zone. He wanted him to assess the hazards they would be facing. Mr. Ewald went to the food court with Capt. Thomas and volunteer firefighter William Elliott.<sup>53</sup> Chief Officer further instructed the firefighters to clear the second floor of any people who might still be there.<sup>54</sup>

Capt. Thomas testified that they entered the Mall from the walkway on the second level and walked to the food court area. They stayed close to one another and looked for hazards and individuals who might still be inside. Capt. Thomas did not see anyone in the food court or hear any sounds from the collapse zone. On the second floor, he saw "[a] lot of dust, wires hanging, things still falling, beams swinging." He also observed someone looking down from the rooftop but noted it was not a firefighter.<sup>55</sup> They then went to the escalators to check whether anybody was trapped, but found no one. They walked to the other side of the collapse zone, on the second floor, to assess the area and ultimately left the Mall the same way they had entered. Capt. Thomas constantly communicated with Chief Officer via radio from inside the Mall to update him. Communications over radio are audible by all members of the Fire Department who have a radio at hand. Outside, the rescue team reported its findings to Chief Officer.<sup>56</sup>

At this stage, Chief Officer was still assembling information and setting up the area. The Fire Department members had to put in place a rapid intervention team, which consists of two firefighters who would be on standby, ready to rescue any firefighter inside the Mall who was hurt. Furthermore, accountability had to be set up in order to keep track of every firefighter's whereabouts.<sup>57</sup>

Accountability is a system used by the Fire Department to track each firefighter's location at any given time. In most situations there will be two locations for accountability: one at the command post, to track who is on the scene, and another by the entry to the "hot zone," to track who is in that area. During the response to the Mall collapse, these two zones of accountability were merged. A board was placed against a truck that was parked immediately in front of the Mall. The board listed the names of the firefighters, and they were all responsible for placing their tags on the "in" or "out" column beside their names. The firefighters also had to write the time next to their names, using the clock placed above the board. This system allowed anyone to see whether a given individual was in the hot zone and, if so, from what time. In any emergency, a firefighter is always designated to stand by the accountability post and to monitor it.<sup>58</sup> I pause to mention that, as the events unfolded, the Elliot Lake Fire Department was responsible for accountability of all the responders, regardless of their team.

In addition to the general accountability system, the incident commander can demand that a personal accountability report (PAR) be performed to ensure that all firefighters are accounted for. In this verification process, a designated person calls each firefighter, or team of firefighters working together, via radio and asks them all to identify their location. That way, everyone's whereabouts are determined at that particular time. The PAR can be done, for example, when there is a drastic change of events on the scene. Although it is seemingly a quick exercise, it can take a lengthy period because the radio is being used constantly, and the firefighters may be performing tasks that could delay their response.<sup>59</sup>



**Figure 2.3.5 Accountability system for Elliot Lake firefighters**

Source Exhibit 7941



Chief Officer testified that the utilities' switches were located in a lockbox which was accessible to the firefighters from the exterior of the Mall.<sup>60</sup> Capt. Thomas stated that a Mall employee unlocked it, thereby providing the firefighters with access.<sup>61</sup> Chief Officer explained that it was difficult to communicate at this time because of a loud fire bell. When he approached the utilities area, he saw that the main water feed was sheared off, allowing water to flow onto the debris pile. Gas meters also had to be shut off, and he dispatched one or two firefighters for that task.<sup>62</sup>

**Union Gas responded quickly, but before its workers arrived the valve had snapped off and the gas was free flowing out of the gas line.**

Capt. Thomas testified that he was unable to shut off the gas because the main feed valve was seized. He notified Capt. George, and they made arrangements to have Union Gas take care of the problem. Union Gas responded quickly, but before its workers arrived the valve had snapped off and the gas was free flowing out of the gas line.<sup>63</sup>

Chief Officer was facing the front doors of the Mall when the valve snapped, at 2:57 p.m. Capt. Darren Connors was pulling up with the other pumper at the same time. Capt. Thomas communicated with Capt. Connors on the radio to stop the vehicle. Chief Officer described how everyone cleared out of the area "because this thing was just screaming when it broke." This break created very hazardous conditions, which required the Fire Department team to evacuate everyone standing nearby. Chief Officer shut off the first pumper and his car to eliminate all sources of ignition and, as he was about to break the window of a parked OPP vehicle to shut it off, the gas "started to fizzle out."<sup>64</sup>

I conclude that the Elliot Lake Fire Department acted promptly and efficiently when it arrived on the scene. As a first course of action, the firefighters shut off the utilities, thereby eliminating an additional source of danger to a situation that was already unsafe.

## **2:49 p.m.: Chief Officer activates the Emergency Control Group**

Chief Officer's notes indicate that, at 2:49 p.m., he "[c]alled dispatch to activate the Emergency Control Group."<sup>65</sup> He testified that he is a member of the Community Control Group (CCG) by virtue of his position as chief of the Fire Service.<sup>66</sup> As noted earlier, the CCG's role during an emergency is to provide support to the incident commander. It also considers the well-being of the community at large: City services have to keep operating during an emergency, which might last several days. The mayor is the chair of the group, and all attendees are asked to provide their updates. During the response to the Mall collapse, the meetings allowed everyone to be informed of the steps that had to be taken over the next period.<sup>67</sup>

When asked why he activated the CCG, Chief Officer testified: "I knew it was going to be an event that needed to activate the group. It is not your typical call. I knew it was going to be hours, and I knew I was going to need their help."<sup>68</sup> Chief Officer had not yet been in the Mall, and his decision was based on what Mr. Ewald had reported to him.<sup>69</sup>

At approximately the same time, Chief Officer asked the OPP's Sgt. Brian Fay to clear the roof deck. He also instructed a member of the rescue team to clear the Mall, starting from the area where Zellers was located.<sup>70</sup>

Realizing that the situation was beyond the Fire Department's capabilities, Chief Officer, according to his notes, "[t]ried contacting Bob Thorpe OFM [Office of the Fire Marshal] via cell phone on site to get heavy rescue" at 3 p.m.<sup>71</sup> Chief Officer knew about HUSAR/TF3, the Heavy Urban Search and Rescue Task Force 3 team operated by the City of Toronto, from some of the training he had undergone as well as through a communiqué he received from the Office of the Ontario Fire Marshal on how to activate the team. However, he did not know

exactly what it was able to do.<sup>72</sup> He was advised that the Provincial Emergency Operations Centre would not dispatch HUSAR/TF3 without a municipal declaration of emergency. He called Mr. Thorpe in an attempt to “work the back channels” and to give him notice that the process of declaring an emergency would soon begin. Initially he was unsuccessful in reaching Mr. Thorpe, but was able to contact him within the next half hour.<sup>73</sup>

### 3:01 p.m.: Chief Officer and other members of the Fire Department enter the Mall

The notes written by Chief Officer state that at 2:56 p.m., he asked firefighter Kluge to “work the pile from the north side for signs of life.”<sup>74</sup> He gave this order to Mr. Kluge because he was already in the Mall in order to silence the alarm. Chief Officer had not yet gone inside the Mall, and his knowledge of its condition was based on what he saw through the front doors and what Mr. Ewald had reported back.<sup>75</sup>

At 3:01 p.m., once the gas valve had been shut off, Chief Officer instructed Capt. Thomas and firefighters William Elliott and Wayne Millett to enter the collapse zone and to look for survivors, moving debris out of the way if necessary. He also communicated via radio, for all Fire Department members to hear, that they were to be “careful not to move anything that would cause further collapse.”<sup>76</sup> Capt. Thomas testified that they entered through the set of double doors at the main entrance and proceeded toward the collapse zone, climbing over debris in the process.<sup>77</sup>

Very shortly after the rescue team went into the Mall, Chief Officer and Mr. Ewald made their way in as well.<sup>78</sup> From his standpoint near the collapse zone, Chief Officer observed a slab hanging at 45 degrees and resting on the escalator.<sup>79</sup> He was greatly concerned about the precarious state of the slabs and the escalator. He could also see the dangerous position of the fallen beam. Referring to the slabs, he described the scene succinctly: “It really scared the bejeesus out of me, if you could put it one way. It was not a good situation.”<sup>80</sup> When asked whether he had any idea how to handle the emergency, he testified that “what we were hoping to do was get in there, and [see] if there was anybody that was accessible. With our limited resources ... the size of the material that we had to deal with was way beyond our capability.” The firefighters managed to move smaller pieces of debris and checked voids for potential victims.<sup>81</sup>

As Chief Officer and Mr. Ewald made their way back to the command post, Capt. Connors was instructed at 3:04 p.m. to help with the search of the main collapse zone.<sup>82</sup> The command post was set up in front of the Mall, to the left of the main entrance. The chief chose that location because it was close to the Mall as well as his best vantage point. Moreover, it allowed the firefighters to tag themselves for accountability without having to walk far.<sup>83</sup>



**Figure 2.3.6 The debris faced by firefighters**

Source Exhibit 7798



Capt. Connors entered the Mall through the doors near the Foodland store. He described the site upon entry as follows:

On approach to the doors, you saw nothing. The doors, they looked dark. Going through those doors, it was almost black. When you cleared the second set of doors, you were standing in water and light debris. You could hear the water running. When your eyes started to adjust, you could see the daylight from the collapse zone, and the lottery kiosk was right in front of you, the main floor one where the escalator goes up behind it, you could go around from both sides, and it was literally curtains I would call it of concrete slabs ... I couldn't walk standing up going through there. You would have to duck or move to the side. And so between the concrete, rebar, pipes, everything was hanging down in that area until you got past it.<sup>84</sup>

He walked to the right side of the kiosk in order to enter the collapse zone.<sup>85</sup> He informed the Chief that there was a heavy load on the beam and that he was not sure how long the beam would support that weight. He continued to search and move debris on the pile. He also checked the vehicle in the rubble for survivors. While he was on the pile, he heard noise from the water flowing in, the fire trucks, radio communications, chatter from other individuals on the pile, and, later on, the sound of blades from the OPP helicopter.<sup>86</sup>

### 3 p.m.: The Community Control Group meets to discuss the declaration of an emergency

The CCG met at 3 p.m. at city hall. Natalie Bray, the administrative assistant to the chief administrative officer, was the duty officer for the CCG as well as the scribe during its meetings.<sup>87</sup> The notes of the meeting indicate that it is "not necessary to declare an emergency right now."<sup>88</sup> Mayor Richard Hamilton testified that not all CCG members were present at the meeting and that he did not have all the information he needed to decide whether an emergency had to be declared.<sup>89</sup> It would appear that Chief Officer had not spoken to any CCG members at that point.

Robert deBortoli, the chief administrative officer for Elliot Lake, testified that when the notation was made, the attendees were still assessing the situation and wanted to make sure they were following the correct procedure. In this regard, he knew that the CCG had to meet, the mayor had to declare the emergency, and documents had to be submitted to the province. However, he had not gone through this process before. Throughout the response, Mr. deBortoli communicated with Chief Officer and reported back to the CCG on particulars going on at the scene.<sup>90</sup>

Michael Mantha, the MPP for the Algoma-Manitoulin riding in which Elliot Lake is located, had an office in the Mall. He found out that the roof had collapsed at approximately 3 p.m., after he left a meeting in the Espanola-Manitoulin area. When he returned to Elliot Lake, he went directly to the Mall. He first ensured that his son and staff were accounted for and subsequently made calls to various ministries to inform them of what had happened and to get "the ball ... moving forward as far as getting the resources here to Elliot Lake." Among others, he phoned the Ministry of Labour, the Ministry of Municipal Affairs and Housing, and the Premier's Office. He did not speak to the mayor because he did not want to get in the way of the rescue efforts. However, he informed some councillors that he wanted to attend a briefing, and he was invited to attend one later on.<sup>91</sup>

Mr. Mantha spent the entire day on the scene, providing whatever information he had to community members. He was aware that the Collins Hall, a city-owned building, had been designated as the place where families of missing individuals could gather to obtain information. He introduced himself to family members there and offered his support.<sup>92</sup>



### 3:04 p.m.: The first victim is located

At 3:04 p.m., volunteer firefighter Elliott informed Chief Officer that his team had located a person trapped in a void. Chief Officer was outside when he received this radio transmission. He did not recall whether he provided instructions to Mr. Elliott right away, but paramedics were eventually sent in to determine whether the person was deceased.<sup>93</sup> This report appears to have been the first indication that there might be a victim in the rubble.

A couple of minutes later, Chief Officer noted that the personal accountability report had been completed and that all firefighters were accounted for. He testified that a head count had been done at his request and that it took 15 minutes to complete: the radio was being used by several individuals, making it difficult for the accountability officer to get through.<sup>94</sup> The PAR was diligently performed at Chief Officer's request and demonstrated that the safety of the Fire Department personnel was a top priority.

### 3:55 p.m.: A state of emergency is declared

When Chief Officer could not reach Mr. Thorpe on his first attempt, he instructed dispatch to contact the Office of the Fire Marshal, to request that the heavy rescue team be deployed. The following excerpt from his notes documents the efforts leading up to the activation of HUSAR/TF3:

15:08:05 IC radioed base to contact OFM for Heavy Rescue.

...

15:14:29 IC advises to give my cell number to OFM to call directly on the scene.

...

15:26:26 IC requested through base to request HUSAR from OFM advisor Bob Thorpe

...

Approx 15:36:14 IC talking to Bob Thorpe OFM local adviser to ensure HUSAR has been activated. He advised he is on it

...

Approx 15:39 IC on phone with Bob Thorpe again, was Husar activated?

15:41:43 IC called base to have them call Provincial Operations centre to request HUSAR activation

15:45:14 Through the calls from the OFM we were advised that the mayor will have to declare an Emergency. OFM are already moving on it anyway.

Approx 15:45 On the phone with Carolyn Chambers OFM advisor to activate HUSAR. And she offered assistance.<sup>95</sup>

Staff Insp. William Neadles was the on-call site commander of the HUSAR/TF3 team. He received a call at 3:45 p.m. from Toronto Fire Services Communications regarding the collapse. His notes state: "Not much info. OFM – Looking to 'stand up' the HUSAR Team – How long will it take."<sup>96</sup> He explained that he wanted to find out the length of time needed to deploy the team.<sup>97</sup>

At 3:55 p.m., Mayor Hamilton officially declared an emergency in Elliot Lake, finally confident that he had sufficient information to make that call.<sup>98</sup> The declaration of emergency, signed by Mayor Hamilton, was faxed to the Provincial Emergency Operations Centre at 4:03 p.m.<sup>99</sup>

As will be seen later, HUSAR/TF3 was deployed shortly after 4 p.m.

I am satisfied that Chief Officer acted promptly in communicating with Fire Department dispatch as well as in making phone calls on his own to activate the HUSAR/TF3 team. He assessed the situation efficiently and, as soon as he established that the Fire Department could not handle the situation on its own, proceeded to reach out to the appropriate individuals.

### 3:28 p.m.: The first communication with a victim is made

Chief Officer's notes state that at 3:28 p.m., Capt. Connors reported having communicated with a victim.<sup>100</sup> It would appear, however, that it was Capt. Thomas who made first contact with the victim. Capt. Thomas and his team called out to ask whether anyone was there. They also looked into voids for limbs or bodily fluids. When he called out, Capt. Thomas described hearing a muffled noise. He then said, "Fire Department, can you hear me?"



**Figure 2.3.7 The area where the two victims were eventually found and where muffled noises were heard**

Source Exhibit 8104

and heard another muffled noise. He tried identifying where the sound was coming from and found a void he believed was the source of the sound.<sup>101</sup>

Capt. Thomas testified that he continued trying for 20 minutes to communicate with the person he believed was responding to his calls. In that time, he obtained a response in the form of a muffled noise to each of the six to 10 questions he asked. Afterwards, he passed the task on to Capt. Connors while he tried to figure out what they could move without having a piece of concrete collapse on them.<sup>102</sup>

Capt. Connors's notes for his Fire Department witness statement indicate that he took over communicating with the victim from Capt. Thomas: "Approx ... 15 30 I took over communicating with victim. All coms with victim were mumbled. We tried to move what we could to get to her. OPP officers set up as eyes for safety for us."<sup>103</sup> In his radio communication with

Chief Officer, Capt. Connors referred to the voice as belonging to a woman because it seemed more feminine to him. In fact, he appeared very confident that he was communicating with the victim, and he even informed Chief Officer that he was "almost certain" that she was a staff member of Dollarama.<sup>104</sup>

Capt. Connors testified that he tried to determine whether she was an employee or a shopper by asking "yes" or "no" questions. He also told the victim to mumble twice for "yes" and once for "no," and he believed the victim followed his instruction when he asked whether she was an employee of the Mall. The delay between his questions and the answers was 10 to 15 seconds.<sup>105</sup> He did not know how long these communications went on for, but he asked approximately five questions, repeating each a few times. Eventually, the victim stopped responding. He was assigned something else, and another individual took over this task.<sup>106</sup>

Chief Officer testified that he knew that these sounds did not come from the same individual as the one that volunteer firefighter Elliott had brought to his attention. Capt. Connors and Capt. Thomas were in a different location on the pile.<sup>107</sup>

While the apparent communications with the victim were taking place, the firefighters were trying as best as they could to get to the victim who was underneath the fallen concrete. Various pieces of equipment were used without any success. These efforts continued after the communications with the victim stopped. The firefighters were very much aware of the dangers associated with moving the concrete, which meant they had to proceed with great caution in order not to cause a further collapse.<sup>108</sup> Capt. Thomas described the effort as follows: "We were trying to figure out what we could do with what we had and try not to bring everything else down on us, because there was so much stuff still dropping."<sup>109</sup>

## 4 p.m.: Chief Officer updates City personnel and the OPP

Shortly after 4 p.m., Chief Officer updated the mayor, Robert deBortoli, and a member of the OPP on the situation at the scene. He told the mayor that two or three individuals were missing. He spoke to Mr. deBortoli about the need for HUSAR/TF3. He also told Mr. deBortoli that two people were missing and that this information could be released to the public.<sup>110</sup>

As the incident commander, Chief Officer assigned tasks to some of the OPP officers who were on scene. He instructed two of them to act as spotters, one facing the concrete slabs resting on the escalators, and the other looking at the doors of the rooftop entrance to the Hotel which hung over the edge of the collapse zone. The officers were instructed to shout out if any hazards moved or fell. Moreover, Capt. Ken Barnes was appointed as the sector and safety officer in the collapse zone, meaning he was responsible for ensuring that the firefighters were safe from all hazards, not simply the ones the OPP were spotting.<sup>111</sup> Capt. Thomas described the safety officer's responsibility as follows:

His responsibility was our safety was number one. He was taking note of any changing conditions, looking for hazards. If he seen something that we didn't and then we were in that area, while we were looking, he pointed out and made sure that we were totally aware of what was going on around us. We weren't really paying attention what was going on. We were busy doing what we were doing.<sup>112</sup>

## 4:20 p.m.: Communication with one of the victims is lost; Mrs. Perizzolo is located shortly thereafter

Capt. Thomas informed Chief Officer at 4:20 p.m. that communication with the victim had been lost for about one hour. He also asked Mr. deBortoli for concrete blades and a sewer camera from the Public Works Department.<sup>113</sup> Chief Officer stated that these tools would be used to explore the voids.<sup>114</sup>

Ms. Bray's notes indicate, in the 4:20 p.m. entry: "2 trapped people in kiosk area. One female talking. [Shuffled or shifted] concrete – can't hear her anymore."<sup>115</sup> A second set of notes, taken on a flipchart by Elizabeth Lewis, the assistant to the City treasurer,<sup>116</sup> indicate: "2 trapped people in kiosk area. 1 was talking but concrete shifted + cannot hear them anymore."<sup>117</sup>

Natalie Quinn, who was a volunteer firefighter at the time of the event, took handwritten notes as the Chief's scribe, starting at 3:12 p.m. Her notes state, at 4:30 p.m., that Chief Officer communicated to the safety officer that, in order to locate one of the victims, they would need to "extricate," by which I presume she meant remove the overlying material. Capt. Thomas explained that Mrs. Perizzolo's body was discovered around that time by volunteer firefighter Jeff Schell in the southeastern part of the collapse zone.<sup>118</sup> He could confirm this fact because he eventually assisted in carrying out her body. When she was found, her hand and foot were visible. Capt. Thomas tried to get a radial pulse on her wrist, but he did not feel one. Therefore, at 4:30 p.m., Capt. Thomas determined that one victim appeared to be deceased. He contacted the Emergency Medical Services by radio and requested that paramedics enter the collapse zone to confirm that the victim was deceased.<sup>119</sup>

Capt. Connors testified that he led the paramedics to the body and subsequently left the collapse area.<sup>120</sup> Chief Officer testified that when the paramedics came back out, they informed him that they believed the victim was deceased. The victim was cold to the touch and non-responsive. They also believed, based on the age spots on her hands, it was an older female. Chief Officer overheard one of the paramedics say that they did not think the victim was Ms. Aylwin because of the spots. He had confidence in the paramedics' judgment. As of then, he knew that at least two people were trapped in the rubble and that one was deceased. He also knew that the other victim had shown signs of life, but that there had been no communications with this individual for approximately one hour.<sup>121</sup>



At 4:45 p.m., Chief Officer received news that HUSAR/TF3 was assembling from Toronto. He then requested that Staff Insp. Neadles call him. He was also aware that Mr. Thorpe was on his way. Although he was unsure what Mr. Thorpe would do, he was thankful to have any available assistance because he had no idea how to rescue the person who had communicated with the firefighters.<sup>122</sup>

### **3:54 p.m.: Algoma Health Unit seeks vaccines from its office in the Mall**

Chief Officer's notes state that at 3:54 p.m., Marshall Chow from the Algoma Health Unit, a Mall tenant, asked that \$60,000 worth of vaccines be recovered from its office. The request was repeated a few minutes later, at which point he advised, "Base to send Marshal to the scene." At 4:53 p.m., a representative from Algoma Health Unit was on the scene, and Chief Officer instructed Capt. George that an OPP officer would take that person to the unit's office.<sup>123</sup>

Chief Officer explained that he was told that, if these vaccines were not retrieved from the Mall, the Health Unit's flu-shot program would be set back. Staff at the unit were concerned that they would not be able to acquire more. Considering that part of his job as a member of the Fire Department was to save property, Chief Officer decided that the request was important enough to act on.<sup>124</sup>

### **5 p.m.: The firefighters in the Mall use sewer cameras in an attempt to find missing persons**

Capt. Connors testified that once communications with the victim stopped, a sewer camera was brought to the rubble pile. In his Fire Department witness statement, he wrote:

I then suggested to get the sewer camera from Public Works to assist in search. I viewed the travels of the camera from a screen on the truck while Vance and Thomas probed with the camera. I don't recall how long we did this, but unfortunately found nothing. At this time, the OPP chopper was hovering overhead, causing vibrations in the truck and in the collapse zone. This is when we realized how unstable the zone was.<sup>125</sup>

Capt. Connors sat on the tail board of the truck, in front of the Mall, watching the monitor and instructing Capt. Thomas, who operated the camera, to move it one way or the other. The camera had a light that allowed for enhanced viewing. He explained that it was often not possible to determine the size of the void until he saw something recognizable, such as a pack of cigarettes. He mainly saw debris, including pieces of concrete or insulation, and the occasional magazine. He did not see clothing or a body part, such as someone's hand.<sup>126</sup>

Capt. Thomas explained that the camera was located at the end of a long hose and that he tried inserting it into all the voids he could find, following Capt. Connors's instructions. He checked the entire collapse area in detail, which took him 45 minutes to one hour. While he was on the pile, he heard radio chatter, trucks running outside, a helicopter flying overhead, and a lot of voices. Several pieces of debris were also dropping around them. However, he specified that the sound they had heard earlier from the victim was different from any of the other noises.<sup>127</sup>

Capt. Connors observed movement from dust and small pieces of concrete on the monitor. When the OPP helicopter was overhead (the ordering of the helicopter is discussed later in this chapter), he noticed more movement – in the sense of an "increase of the small debris raining down in front of the camera." After the helicopter left, the movement settled somewhat. He did not go back to the pile once the work with the camera was complete because Capt. Barnes, the safety officer, and Chief Officer had called everyone out except for Capt. Thomas and firefighter Adam Vance. Capt. Connors believed that Capt. Barnes's main concern was the stability of the severed beam and the doors hanging overhead.<sup>128</sup>

While rescuers were still in the rubble, Chief Officer asked them to check the cavity between the two escalators to ensure that no one was trapped there. They did, but found no one.<sup>129</sup> Shortly thereafter, at 5:05 p.m., Chief Officer's notes state:

I went into the scene and spoke to Ken Barnes and he felt the crews have done all they can and the area is very dangerous. I observed the crews trying to slide an 8 x12 hollow core slab down the pile. I had grave concern that the slab would smash into the hanging slabs off of the escalator[,] causing a further collapse.<sup>130</sup>

Chief Officer accessed the rubble pile on the right side of the escalators at ground level. By that point, his men had cleared a way to the pile which enabled him to proceed in a straight line. He witnessed a few firefighters on each side of a hanging slab, trying manually to move it. He stated:

I was really afraid that that was going to cascade down and slide into the vertical material that was hanging off of the escalator. And once a chunk of that size got going, if there is legs in the way, it is going to cut them right off. And that was when I pulled everybody out of there.<sup>131</sup>

At 5:07 p.m., Chief Officer pulled everyone out of the hot zone except for Capt. Barnes, Capt. Thomas, and firefighter Vance, who stayed in the pile.<sup>132</sup> They continued to search voids and probe holes with the camera. At 5:47 p.m., Capt. Barnes told Chief Officer that they had exhausted all their options and that they were risking lives. Capt. Barnes also asked the chief whether he wanted them to mark the position of the body of the victim they had located. He advised them to do so at 5:53 p.m.<sup>133</sup>

## 6:14 p.m.: Firefighters are pulled out of the collapse zone

At 6:14 p.m., Capt. Barnes evacuated the collapse zone completely because the OPP helicopter flying above caused the hanging beam and the set of double doors on the rooftop level to sway a lot more.<sup>134</sup> Capt. Thomas testified that he agreed with Capt. Barnes's order. However, he did not leave the site immediately and was ultimately pulled out by Chief Officer.<sup>135</sup>

Chief Officer had not been informed by the OPP that a helicopter had been ordered. When Capt. Barnes informed him that the rotor wash – the air movement caused by the rotors of the helicopter – was being felt in the collapse zone, he tried to contact an OPP member to have the helicopter waved off. He testified that he pulled his crew out at that time not only because of the effect of the rotor wash but also because they had done everything they could. When asked whether the increase of movement on the pile due to the rotor wash was significant, he replied: "Any increase in a hazardous condition is significant."<sup>136</sup>

**At 6:14 p.m., Capt. Barnes evacuated the collapse zone completely because the OPP helicopter flying above caused the hanging beam and the set of double doors on the rooftop level to sway a lot more.**

The Fire Department does not have a radio linked to the OPP communications system. Every agency has its own frequencies, making inter-agency communications difficult. Chief Officer agreed that it would make sense to enable the incident commander to have direct communication with the leads of the other agencies at the scene. If he had been able to communicate with the lead from the OPP directly, the helicopter could have been waved off more quickly. It should be noted that the OPP members on the ground also could not communicate directly with the pilots. Between two and four minutes elapsed, from the moment Chief Officer was made aware of the problem, before the helicopter was instructed to leave the area above the collapse.<sup>137</sup>

## 6:30 p.m.: Chief Officer attends the Community Control Group meeting

Capt. Thomas testified that, after the collapse area was clear of personnel, he was informed that the OPP's UCRT team was arriving and that the HUSAR/TF3 team had been activated. During the rest of the day, as well as through the night, he was either at the Mall or at the fire station. He believed that, given the condition of the collapse area, the Fire Department could not have moved any further debris without heavy equipment. Moreover, no one in Elliot Lake had the necessary equipment to assist; they had to await the arrival of the UCRT and HUSAR/TF3 teams.<sup>138</sup>

At 5:29 p.m., Chief Officer was advised that the chemical, biological, radiological, nuclear, and explosive (CBRNE) team had left its Gravenhurst base and was on its way to Elliot Lake. He testified that he was not aware they were part of the UCRT team. Therefore, at 6:30 p.m., when he attended the Community Control Group meeting, he did not realize that the UCRT team was on its way to Elliot Lake.<sup>139</sup>

Chief Officer informed the attendees at the meeting that he had activated the mutual aid protocol with the Blind River Fire Department. He also provided an update about what he had done at the scene until then. With regard to the victims, Ms. Bray's notes of the chief's update state:

Victim – trying to get to. Very muffled response for 45 mins – Attempted to locate, scene is very unsafe. Concrete slabs hanging by cables. 1 hour after could not hear her anymore.

Got to a limb – foot – no pulse verified – not confirming fatality. 2 hrs after trying to make way – pulled everyone out.<sup>140</sup>

Chief Officer did not understand why the notation "not confirming fatality" was made. He had informed the CCG members that there was a casualty and that the EMS had confirmed that one victim had no pulse.<sup>141</sup>

After the meeting, at 8 p.m., he returned to the fire hall and spoke with the firefighters. He told them that they had done a "good job" and that their work was appreciated.<sup>142</sup> He went to the scene on a couple of occasions that evening, and ultimately met the UCRT and MOL representatives who arrived that night. He also attended the CCG meeting at 10:05 p.m., when he reported on the status of the UCRT, MOL, and HUSAR/TF3 teams and discussed next steps.<sup>143</sup>

## Deployment of the OPP

In this section, I describe the initial actions of OPP resources that were deployed in response to the collapse. The main focus is on the deployment of the UCRT as well as the actions of the local OPP forces in Elliot Lake during the first 10 hours of the emergency response. Just as in the rest of this Report, the biographical description of all individuals, including their rank, reflects their status on the date they testified and is not necessarily current.

### The command structure and complement of UCRT

As noted above, a staff sergeant is in overall command of the UCRT team. When the Mall collapsed, Staff Sgt. Jim Bock occupied that position. The urban search and rescue (USAR) and CBRNE elements of UCRT are each commanded by sergeants. In June 2012, Sgt. Mike Dolderman was in command of the USAR element, and Sgt. Meshach Parsons was in command of the CBRNE element.<sup>144</sup>

The command structure of UCRT also includes an administrative sergeant. As of June 23, 2012, that position was occupied by Sgt. Jamie Gillespie. His duties are both administrative and operational. He was responsible for conducting most of the scheduling of the shifts of team members, budgeting, reviewing operational reports, and



generally all elements related to the administration of UCRT. Sgt. Gillespie is an OPP veteran. He joined the OPP in 1991 in Waterloo and became a part of the Provincial Emergency Response Team (PERT) in 2003. He became a member of the UCRT team after it was created out of former elements of the PERT in 2010.<sup>145</sup>

Sgt. Gillespie is a fully trained and experienced member of UCRT and is capable of participating in any team operation.<sup>146</sup> Specifically, he is trained to the technician level in structural collapse in accordance with the US National Fire Protection Association (NFPA) 1670 standard and, since 2003, has taken more than 100 hours of structural collapse training at Texas A&M Engineering Extension Service (TEEX).<sup>147</sup>

Cst. Ryan Cox is a constable with the OPP and has been with the force for 10 years. He joined the UCRT team in 2010.<sup>148</sup> Cst. Cox is trained to the NFPA 1670 technician level in structural collapse.<sup>149</sup> He has attended structural collapse rescue training at TEEX, where he learned how to conduct rigging operations – including how to move debris by lifting it and moving it with ropes and other lines.<sup>150</sup>

Cst. Dan Bailey is a constable in the USAR element of the UCRT as a canine handler. He joined the OPP in 1998, after working, among other things, as a certified firefighter with the London Fire Department. He began training dogs through the Canadian Kennel Club in 1994 and, in 2005, became a canine handler with the OPP.<sup>151</sup> He has undergone extensive training as a canine handler, both for the OPP generally and specifically for his UCRT responsibilities. This training has included canine urban search and rescue as well as cadaver detection courses. In addition, Cst. Bailey has taken canine search specialist training with the American Federal Emergency Management Agency (FEMA).<sup>152</sup> At the time of his deployment to Elliot Lake, he was responsible for two dogs, Dare and Charlie.<sup>153</sup>

Cst. Steve Hulsman joined the UCRT in 2010. He is trained to the technician level in structural collapse rescue, confined space rescue, and high-angle rope rescue.<sup>154</sup> He also has training in the use of ground-penetrating radar, and this skill, along with other technical search tools, is his specialty in the UCRT.<sup>155</sup> Before his involvement in the Elliot Lake Mall collapse, he had previous hands-on experience with structural collapses, including the recovery efforts after a building explosion in Woodstock and the tornado in Goderich, both in 2011.<sup>156</sup>

Cst. Patrick Waddick has been a member of UCRT since 2011. Previously, as an industrial mechanic, he had worked regularly with cranes and other heavy equipment. He also served as a volunteer firefighter.<sup>157</sup> As a UCRT member, Cst. Waddick received extensive training, including at TEEX, in all manner of structural collapse rescue techniques.<sup>158</sup>

## 2:34 p.m.: UCRT is mobilized

The mobilization of UCRT in response to the Algo Mall collapse began at 2:34 p.m., when the OPP's General Headquarters Duty Office contacted Sgt. Gillespie. He testified that Staff Sgt. Bock was not available to answer the call, and that the sergeants in charge of the USAR and the CBRNE elements of the team were on vacation. Accordingly, as the administrative sergeant, Sgt. Gillespie was the highest-ranking officer able to receive the call.<sup>159</sup>

Sgt. Gillespie was informed of the structural collapse of a mall in Elliot Lake and given the contact information for Insp. Percy Jollymore, the local (East Algoma) OPP detachment commander.<sup>160</sup> First, however, he tried to contact Staff Sgt. Bock, because he would normally be the decision-maker for mobilization of the team. Sgt. Gillespie sent out an email and a text message that would be received by all team members unless they were on vacation or their phones were off. He testified that he even attempted to contact the members of the UCRT team who were on vacation. As noted above, as of June 23, 2012, the complement of UCRT members was 23. Of that number, one member was on parental leave, five were on holiday, and one was in Montreal. Accordingly, only 16 were in

a position to respond.<sup>161</sup> Sgt. Gillespie testified that, in the circumstances, he would have liked every member of the UCRT members to respond, “but that wasn’t going to happen.”<sup>162</sup> In all, only 10 members of the UCRT team indicated that they were available to deploy.<sup>163</sup>

Soon thereafter, Sgt. Gillespie called Insp. Jollymore, who advised him that the rooftop parking at the Algo Mall had collapsed and that people were missing – and likely trapped. Sgt. Gillespie advised Insp. Jollymore that UCRT would have a response time of approximately six to seven hours. They did not discuss what supplies or equipment UCRT might require.<sup>164</sup>

The protocol for a request for UCRT services provides that the OPP General Headquarters Duty Office should immediately notify the commander of UCRT.<sup>165</sup> By initiating the deployment of the team, Sgt. Gillespie acknowledged that, because he was not the team commander, he was breaking with UCRT protocol. He testified that he made this decision “based on the urgency, that the facts were that people were trapped and we needed a response so I did not expect any issue. I was unable to get ahold of my chain of command so I made that decision on my own.”<sup>166</sup>

Sgt. Gillespie is to be commended for acting as decisively and as swiftly as he did in mobilizing and deploying UCRT.

## **2:39 p.m.: Cst. Cox is put in command of UCRT as it mobilizes**

Cst. Cox learned about the collapse in Elliot Lake in a telephone call from Sgt. Gillespie at 2:39 p.m. In that phone call, Cst. Cox testified, Sgt. Gillespie advised that the collapse had occurred approximately 15 minutes earlier. Cst. Cox thought this brief lag was a good sign because, normally, calls for such emergencies are not received by the UCRT team so rapidly. At that time, Cst. Cox was close to his home in Hamilton.

Because Sgt. Dolderman was on vacation, Cst. Cox had been put in charge of the USAR element of UCRT as acting sergeant about a week before June 23.<sup>167</sup> In the preliminary stages of the deployment of the team, Sgt. Gillespie left to Cst. Cox the responsibility for determining what equipment would assist in attempting to access any trapped victims.<sup>168</sup> He also told Cst. Cox that, as acting sergeant, he would be in charge of the UCRT response until he himself arrived at the scene.

Cst. Cox testified that Sgt. Gillespie instructed him to contact Insp. Jollymore, whom he identified as the incident commander. He also stated that, in his understanding, although he was to report to Insp. Jollymore, he did not necessarily have to take orders from him.<sup>169</sup>

## **4:16 p.m.: UCRT advance team leaves for Elliot Lake**

After speaking with Sgt. Gillespie, Cst. Cox drove to the UCRT office in Bolton, approximately 70 kilometres from Hamilton. He made sure that everything was organized and that the team had the vehicles and the assets they would take with them. Because Cst. Waddick lives close to the Bolton office, he had already been assigned this task, and, therefore, it was substantially complete by the time Cst. Cox arrived. Cst. Cox assigned the UCRT team members to vehicles while they were still finishing their preparations. He then requested that Cst. Chris Collins drive him in his vehicle to Elliot Lake. As a result, Cst. Cox left ahead of the rest of the team.<sup>170</sup> He departed for Elliot Lake at 4:16 p.m. on June 23. When he left, he was aware that there had been a collapse of a parking structure in or around a mall and that an unknown number of people were trapped in the debris. He had no further information.<sup>171</sup>

Cst. Waddick was in Sgt. Gillespie’s backyard enjoying a barbecue when they received the call from the Duty Office.<sup>172</sup> Sgt. Gillespie instructed Cst. Waddick to go to the UCRT offices in Bolton immediately, first to prepare the USAR trailer and ensure that all its equipment was in place, and, second, to assist the other members as they

arrived to get ready and en route.<sup>173</sup> The equipment would include power tools, search equipment, cameras, generators, hydraulic power pack, jackhammers, extrication tools, and chainsaws for concrete. Also included on the truck is a full complement of tools related to auto extrication. Cst. Waddick departed for Elliot Lake at 4:30 p.m. He arrived at approximately 9:25 p.m. and did not stop en route.<sup>174</sup>

Cst. Bailey was in Toronto when he received the text message. He returned immediately to his home, loaded Dare and Charlie and some clothing into his truck, and proceeded to Elliot Lake.

At 2:50 p.m., Sgt. Gillespie advised Acting Insp. Wayne Jacklin, who was at the time in charge of OPP emergency management (which oversaw UCRT), that he had paged the entire team and that 10 full-time members and two tactical medics had responded. Sgt. Gillespie further advised that he would manage the incident. Initially, he would manage by phone, because he had to attend to child-care issues, and that he would go to the scene as soon as possible.<sup>175</sup>

Sgt. Gillespie, at 3:35 p.m., contacted Insp. Jacklin to request the assistance of HUSAR/TF3. He took this step because, from his experience, the rescue of trapped persons from a collapsed building could take many days. Moreover, because of the limited number of team members UCRT would have available to respond to the emergency, HUSAR/TF3, with its larger force, should be activated. In addition, Sgt. Gillespie contacted Carol-Lynn Chambers of the Office of the Fire Marshal to advise her of the numbers that the UCRT had available to respond to the emergency.<sup>176</sup>

Very soon after receiving notice of the collapse, Ms. Chambers contacted the OPP Duty Office to reach Staff Sgt. Bock. When she could not reach him, she spoke with the next person in the UCRT command structure, who she understood to be Sgt. Gillespie.<sup>177</sup> Ms. Chambers testified that she contacted Sgt. Gillespie in order to get him to coordinate with HUSAR/TF3. She expected that UCRT would arrive at the scene more quickly, and it would therefore be helpful for the two operational units to share information by connecting directly and coordinating their requirements.<sup>178</sup> Sgt. Gillespie left Bolton for Elliot Lake at approximately 7 p.m. on June 23.<sup>179</sup>

## 2:33 p.m.: OPP local forces in Elliot Lake respond

Insp. Percy Jollymore is the detachment commander for the East Algoma region. This region has 11 communities, of which Elliot Lake is the largest. Insp. Jollymore joined the OPP in 1975 and rose through the ranks to his present position in 2009.<sup>180</sup>

Insp. Jollymore stated that he first became aware of the collapse at the Algo Mall at approximately 2:33 p.m. on June 23. He was initially contacted by the Provincial Communications Centre in North Bay.<sup>181</sup>

At 2:33 p.m., Sgt. Brian Fay, the sergeant then on duty in Elliot Lake, advised Insp. Jollymore that he was on the scene and that the OPP was overwhelmed with calls. As a result, the inspector immediately went to the Algo Mall. When he arrived, he found that the scene was not secure and that no scene control was in place. He noticed that the main entrance of the Mall was completely clogged with people and vehicles: a perimeter had not yet been established to funnel people safely away and to ensure that first responders could continue their work.<sup>182</sup> He gave directions to have the process of securing the scene started. He then communicated with the Provincial Communication Centre to state that he intended to take charge of the OPP at the scene.<sup>183</sup>

Insp. Jollymore instructed Sgt. Fay to ensure that the building had been cleared. He subsequently summoned additional resources from the East Algoma detachment to assist in establishing a perimeter around the entire building so that the OPP could keep track of who was entering and who was exiting the emergency scene.

Insp. Jollymore estimated that, by 3:30 p.m., all the main entrances to the Mall area had been secured.<sup>184</sup>



Cst. Dale Burns, an OPP identification officer from Sault Ste. Marie, testified that soon after he arrived, Insp. Jollymore ordered him to photograph and videotape the collapsed area from an OPP helicopter. He stated that he did not speak about the order to fly over the Mall in a helicopter with anyone at the scene other than the air crew. Insp. Jollymore agreed that it would have been helpful for the OPP to communicate with the Elliot Lake Fire Department about a helicopter flying overhead.<sup>185</sup>

## Ordering a crane

During the hearings, the issue of ordering a crane for the purpose of removing debris from the collapse zone led to some controversial evidence that is not easy to reconcile. I heard evidence that UCRT requested a crane as early as 5:30 p.m. on June 23. Ultimately, a crane was not ordered until after 11:00 p.m. that evening, when the OPP finally contacted Dave Selvers, the president of Millennium Crane in Sault Ste. Marie.

### 4:30 p.m. to 5:30 p.m.: Cst. Cox identifies the need for a crane

Cst. Cox testified that while en route to Elliot Lake, he was able, by using Google on his smart phone, to find pictures of the Mall collapse. The photographs that he saw on his screen were similar to those in Exhibit 2114.<sup>186</sup> He could see from them that there were heavy concrete slabs in the pile and that those slabs were located in the middle of the collapsed structure, not on the exterior. As a result, Cst. Cox thought that, at some point, the rescue operation would require a crane to assist the operation. He reached this conclusion based on his training with the structural collapse technician courses at TEEX. He had learned there that cranes were usually one of the fastest and safest methods for removing debris from the site of a structural collapse.

At this initial stage, Cst. Cox's plan for the crane was that rescuers would start rigging the slabs and pulling them off the pile one by one, thereby avoiding having to cut slabs that could potentially harm people who were trapped underneath.

When the UCRT team requires a crane, it typically depends on local resources. As a result, the UCRT would normally rely on the commander of the local OPP detachment, in this case Insp. Jollymore, to make the necessary arrangements.<sup>187</sup>

### Insp. Jollymore was not familiar with UCRT

Before working with UCRT in response to the Mall collapse, Insp. Jollymore appeared to have little knowledge of or experience with this organization and its capabilities. He testified as follows:

Q. ... Now, can I switch gears again and this time talk to you about the relationship with UCRT. You are an OPP officer. UCRT is a special tactical unit in the OPP. And what was your relationship – did you have any knowledge of them, or did you ever work with them prior to this collapse?

A. Not under their new title, no.

Q. And when you say not under a new title –

A. Well, they have been reformed and specialized, so they have had a number of names. The unit has had a number of names, and it has done varied things. They are a specialized component of the Emergency Response and Tactics Team.

Q. And did you know what their specialties were at the time of the collapse?

A. I just had general knowledge of them.

Q. And what was that?

A. Just that they were in existence; that they had some specialized skills in relation to search of partly collapsed buildings; and they had some training to that aspect.<sup>188</sup>

Insp. Jollymore also did not have any knowledge about Cst. Cox's role within UCRT.<sup>189</sup> His lack of familiarity with UCRT and Cst. Cox's role on the team may, as I explain later, have influenced his conduct in ordering a crane to deploy to Elliot Lake.

### 5:30 p.m.: Cst. Cox requests a crane

At 5:30 p.m., Cst. Cox spoke with Sgt. Scott Taylor, a member of the Emergency Response Team Unit within the OPP (a unit, distinct from UCRT, which deals with such elements as evidence searches and ground search and rescue). At that time, Sgt. Taylor was in Elliot Lake. He advised Cst. Cox that he would soon be meeting with Insp. Jollymore. Cst. Cox told Sgt. Taylor that he would need at least one crane, lumber, and a structural engineer. Sgt. Taylor advised Cst. Cox that he would advise Insp. Jollymore of the request.<sup>190</sup> Cst. Cox therefore believed that Sgt. Taylor was going to advise Insp. Jollymore that UCRT was requesting at least one crane to conduct the rescue operation.<sup>191</sup>

Insp. Jollymore's notes record that at 6:04 p.m. on June 23 "Ryan Cox attending with urban unit will be the lead. Urban unit requires structural engineer, lumber, photographs, crane ..."<sup>192</sup> Insp. Jollymore testified that this notation did not reflect the conversation he had with Cst. Cox but, rather, a conversation that would have been relayed to him between one of his sergeants and Cst. Cox. Insp. Jollymore could not remember which sergeant had that conversation.<sup>193</sup> He agreed that the conversation recorded at 6:04 p.m. in his notes is the same conversation that Cst. Cox testified he had with Sgt. Taylor at 5:30 p.m.<sup>194</sup>

Cst. Cox spoke directly with Insp. Jollymore at 6:17 p.m., according to his notes. At that time, Cst. Cox advised Insp. Jollymore of his estimated arrival time of 9:30 p.m. and that UCRT would require a structural engineer, a crane, and rigging equipment, which generally comes with the crane, as well as lumber.<sup>195</sup>

Specifically, Cst. Cox made the following entry in his notes: "Spoke with Insp. Jollymore and advised him ETA 21:30 hours according to GPS. I advised him that we would require a structural engineer, a hydraulic crane, rigging equipment, lumber. He advised that he would request those items as he was just going into a meeting but would like to wait until we are on scene to make the orders."<sup>196</sup> In his testimony, he confirmed the accuracy of the notation.<sup>197</sup>

**Cst. Cox advised Insp. Jollymore of his estimated arrival time of 9:30 p.m. and that UCRT would require a structural engineer, a crane, and rigging equipment, which generally comes with the crane, as well as lumber.**

Cst. Cox interpreted this statement from Insp. Jollymore as meaning that he wanted UCRT to be at the scene to do a reconnaissance of the situation, and only then to decide whether it actually needed a crane and the other equipment. He testified that he did not believe that waiting until UCRT arrived on the scene before ordering a crane was a sensible thing to do. Cst. Cox's initial plan was to start operations with a crane as soon as possible. He testified that, having seen the size of the slabs and knowing their weights, he knew a crane would be needed at the outset of the rescue effort. He further testified that, while using tools for lifting and supporting the slabs were potential options, he knew that a crane would be part of the operation.<sup>198</sup> Cst. Cox testified that Insp. Jollymore did not ask him why he thought a crane was necessary. Rather, he advised Insp. Jollymore that, having looked at photos of the scene, he thought that a crane would be necessary.<sup>199</sup>

Sgt. Gillespie testified that while he was en route to Elliot Lake, he had several discussions with Cst. Cox, who advised him that he had seen pictures of the Mall and that he felt the best option was to have a crane involved in the rescue because of the lack of access to the collapsed area.<sup>200</sup> Sgt. Gillespie did not speak with Insp. Jollymore about the ordering of a crane. Instead, he left that to Cst. Cox.<sup>201</sup>

For his part, Insp. Jollymore recalled having the conversation noted in Cst. Cox's notes at 6:17 p.m.<sup>202</sup> He testified that Cst. Cox's notes were not quite accurate because they did not reflect his concerns about the type of crane that Cst. Cox was requesting. He further stated that he issued an order that a crane be ordered following his conversation with Cst. Cox. He wanted, he explained, to make sure that they were ordering the proper equipment and that it would be suitable for the area. He noted that the terrain around the Mall, as well as its layout, presented complications that needed to be addressed. He testified that, in his view, Cst. Cox was not an "expert" in the type of crane that he required because he would not know exactly what type of crane he would need for the Mall in question.<sup>203</sup>

Under examination from Commission counsel, Insp. Jollymore gave evidence that suggests his memory of giving the order to have a crane ordered was uncertain:

Q. So did you order a crane for him or not?

A. We ordered a crane for him.

Q. When did you order it?

A. They were – well ... he convinced me once he started talking about the type of crane and with the wedges to anchor it[,] I gave the okay to go ahead and order ... those items.

Q. And in that same phone call, as you put it at 18:19 p.m.?

A. Yeah. The sergeants were briefed and they were told that that was their assignment.

Q. At 18:19 after that phone call [–] that is reference there [in Inspector Jollymore's notes at Exhibit 6396]?

A. Right after the phone call, yeah.

Q. So they were ordered to get a crane; you were satisfied with the explanation?

A. Well, no. They were ordered to get a crane, lumber, locate a structural engineer, and photograph the scene[,] although that had already started to take place.

...

Q. ... So who did you tell to order the crane?

A. I don't recall which sergeant.<sup>204</sup>

Although insisting that he had given the order to have the crane requisitioned, Insp. Jollymore again appeared uncertain in his testimony about the extent of follow-up on the status of his order. He also appeared somewhat unclear with respect to who, within the chain of command, had authority to make an order for equipment:

Q. And you didn't follow up with anybody about the crane?

A. The crane in particular?

Q. Yes.

A. Well, I think so. I think when we get to later on in the evening there is –

Q. Well, it was ordered finally at 11:15 p.m., and that is on June 23?

A. Yes.

Q. Which was at least, putting the most favourable [light] on who called who when, a five hour delay in ordering the crane. Were you aware of that at that time?

A. There was five hours? No, I wasn't.

Q. And would that have troubled you if you knew?

A. Well, it did bother me, but I mean there is a number of other factors here also, right. Mr. Cox can't operate on his own. His instructions were to report to the incident commander, which is the fire chief, and he has to take his directions from the fire chief. The fire chief, while this was all going on, had closed down the site and evacuated the site because it was unstable and unsafe. So, I mean, I wanted the crane to be there, but I was just being told they couldn't find one –



Q. Who told you that and when?

A. I can't – I can't recall.<sup>205</sup>

Insp. Jollymore later exhibited further uncertainty with respect to the chain of command:

Q. And my question is: In terms of the crane, do you agree with me that it is obvious that there was going to have to be a crane used at this site at some point?

A. Well, that is why I okayed it to be ordered, but, you know, the issue with this, though, is that the logistical officer in this is the incident commander, which is unfortunately the fire chief. I mean ... it is his call on how they are going to do the rescue.

Q. But you undertook to get this crane?

A. I –

Q. You took on that responsibility?

A. I took it on, so when you see the time at 11 o'clock, you'll see that they were talking with the fire chief about the crane and it is actually the ident officer that comes up with the name Millennium Crane to make the phone call.<sup>206</sup>

Despite testifying that, in his view, Cst. Cox should have requested resources such as a crane through Chief Officer, Insp. Jollymore acknowledged that he undertook responsibility to order the crane. Furthermore, he did not advise Chief Officer that he should take responsibility for the crane, nor did he indicate to Cst. Cox that any such request should be made to Chief Officer.<sup>207</sup> Accordingly, if a crane was going to be ordered, it would have to be through him – Insp. Jollymore.

At a CCG meeting at 6:30 p.m., as reflected in the CCG log, the OPP reported: "Ryan Cox Urban Rescue asked for equipment structural engineer on site ... Bruce to find: one heavy hydraulic crane."<sup>208</sup> Mr. deBortoli testified that this note reflects that Insp. Jollymore was advising the CCG of what Cst. Cox had said he needed from the inspector.<sup>209</sup>

Cst. Cox arrived in Elliot Lake at 8:52 p.m. He went to the OPP detachment, where he was advised that Insp. Jollymore and other community officials were waiting to meet with him. Insp. Jollymore advised him of the history of the Mall, including the fact that it had a history of complaints related to water damage. He also provided Cst. Cox with an update on the status of the items he had requested in his earlier phone call, including the crane.

Insp. Jollymore advised Cst. Cox that they were still working to find a crane. Cst. Cox testified that he understood this information to mean that a crane still had not been ordered. He was concerned, yet no one gave him any explanation for the delay. He further testified that he was not certain of the resources in Elliot Lake and its surrounding area. Accordingly, he decided to rely on the local officials in the chain of command to secure those assets.<sup>210</sup>

Later in his examination, when Insp. Jollymore was told that it was Sgt. Fay who had contacted Mr. Selvers, his memory appeared to become somewhat refreshed: he testified that part of the instructions he gave to Sgt. Fay at approximately 6:19 p.m. or earlier in the evening on June 23 were to locate a crane. He stated that he subsequently asked Sgt. Fay why it had taken so long to order the crane. Insp. Jollymore indicated that Sgt. Fay responded by recounting the conversation during which the name of Millennium Crane was first mentioned, which – according to Insp. Jollymore's evidence – occurred *after* Cst. Cox had arrived in Elliot Lake.<sup>211</sup> Given that Cst. Cox did not arrive in Elliot Lake until almost 9 p.m., this evidence is totally inconsistent with Insp. Jollymore's testimony that he gave the order that a crane be obtained following his conversation with Cst. Cox at approximately 6:20 p.m.

The evidence relating to a 10:05 p.m. CCG meeting appears to confirm that Insp. Jollymore did not issue the order for a crane until after UCRT arrived in Elliot Lake. Insp. Jollymore confirmed that he spoke for the OPP at the meeting.<sup>212</sup> The notes from the CCG confirm the following information being provided by Insp. Jollymore in his update at the meeting: "Inquiries about a crane. Wants confirmation first before ordering."<sup>213</sup>

Under examination from Commission counsel, Insp. Jollymore indicated the following information about that notation:

- Q. Is that a note of one of your comments during that meeting?
- A. Yes. But I had already given instructions to order the crane prior to going in there, so –
- Q. So this was –
- A. So I don't know. I –
- Q. Was it –
- A. I can't speak to that. You know what? I really don't know how, the topic of the crane came up but before I went to that meeting Mr. Cox had already convinced me of the type of crane that was needed. So the instructions were given to make the order.
- Q. So when they say "Confirmation first before ordering" you don't know what that means?
- A. I don't – I don't know if that – there was a number of topics there about talking to the fire chief and how it was going to be deployed or the type of crane. There was some talk back and forth but I really – of all of those issues that we talked about.<sup>214</sup>

Mr. deBortoli could not recall what was meant or what he understood from the comment at the 10:05 p.m. meeting that Insp. Jollymore wanted confirmation before ordering the crane.<sup>215</sup> In any event, Cst. Cox was not advised when the crane was finally ordered.

### 11:15 p.m.: The crane is finally ordered

Dave Selvers owns and operates Millennium Crane in Sault Ste. Marie – a company he founded in 2002. Before then, he had extensive experience in crane operation: from 1980 to 1991, he served as a hoisting engineer for various employers; from 1991 to 1994, he worked on the construction of a natural gas pipeline as a crane operator; and from 1994 to 2001, he worked for a company called All Canada Crane, managing its Northern Ontario operations. Mr. Selvers is certified as a hoisting engineer, a designation conferred by the provincial government to people proficient in the use of cranes. The process of becoming a certified hoisting engineer involves a 5,000 to 6,000-hour apprenticeship, which usually takes four to five years to complete.<sup>216</sup>

Before the Algo Mall collapse, Mr. Selvers had operated a crane in emergency situations. For example, he had been involved in situations where crane operations have been necessary to address train collisions and train derailments.<sup>217</sup>

Mr. Selvers testified that, before the collapse of the Algo Mall, he had worked with the OPP on numerous occasions, responding to highway traffic accidents when he was with All Canada Crane or with Millennium Crane. In fact, around 2011, he stated, a representative of the OPP contacted him to ask if he would be willing to be placed on a vital services directory. The OPP later contacted him to let him know that his name had been placed on the list and to confirm the accuracy of their contact information. He testified that, after being placed on the vital services directory, he received no further communication from the OPP.<sup>218</sup> Mr. Selvers had not previously worked with UCRT or with HUSAR/TF3.<sup>219</sup>

At approximately 3 p.m. on June 23, Mr. Selvers explained, he first heard about the collapse at the Mall. He testified that his girlfriend was watching the news and saw a report on the collapse. When his girlfriend said, “Maybe you’ll get a call,” he responded, “Well, I’ll keep the phone on. I’ll be waiting.”<sup>220</sup>

Mr. Selvers testified that he was first contacted by the OPP at 11:15 p.m. in a call from Sgt. Fay. The officer advised Mr. Selvers that he would probably need an 80-tonne-capacity crane. However, Mr. Selvers judged – from his own viewing of pictures he had seen in the media of the collapse zone – that he would need a larger crane, given the length of boom that would be required to access the collapse zone. As a result, Mr. Selvers took it upon himself to send a larger crane to Elliot Lake.<sup>221</sup>

After speaking with Sgt. Fay, Mr. Selvers began the process of mobilizing his crew and the necessary equipment. Given that it was after 11 p.m. on a Saturday night, his crew was dispersed, with many in the bush and out camping.<sup>222</sup>

Mr. Selvers testified that he tried to mobilize a team of 12 to 18 crew members to respond to this type of event. He said that the crew began to assemble at around 1 a.m. and that the equipment he brought with him included welding machines, torches, an assortment of steel, plenty of rigging equipment, and suspended work platforms. He stated that he loaded steel for the purpose of shoring up pillars and columns that might have been compromised in the collapse. He also brought cable lashings and pulleys, to have them available to attach to a leaning column to support it and prevent it from becoming further compromised.<sup>223</sup>

## Conclusion

I accept that Cst. Cox requested that a crane be ordered when he spoke with Sgt. Taylor at 5:30 p.m. I further accept that Cst. Cox directly requested that Insp. Jollymore order a crane when they spoke at 6:17 p.m. However, the crane was not ordered until 11:15 p.m.

On the totality of the evidence I have heard in connection with the ordering of the crane, I am of the opinion that Insp. Jollymore’s memory is – to put it mildly – hazy and imprecise. He appears to have inexplicably refrained from issuing the order to have the crane requisitioned, resulting in a five-hour delay. I discuss the consequences of that delay, both direct and indirect, later in this Report.

**On the totality of the evidence I have heard in connection with the ordering of the crane, I am of the opinion that Insp. Jollymore’s memory is – to put it mildly – hazy and imprecise. He appears to have inexplicably refrained from issuing the order to have the crane requisitioned, resulting in a five-hour delay.**

## 9 p.m.: The initial UCRT reconnaissance

In the discussion that took place at 6:17 p.m., Cst. Cox made other requests of Insp. Jollymore, including that an engineer attend and that the provision of lumber be arranged. Insp. Jollymore advised Cst. Cox that a structural engineer was en route from Sudbury, but Cst. Cox is not sure whether such an engineer ever attended at the scene.

Cst. Cox testified that a structural engineer would have been helpful for two reasons: to advise on the construction of the collapsed building, and to assist with the calculation of loads and weights to help rescuers in shoring the structure for safe operations.

In addition, Sgt. Gillespie testified that he also considered whether a structural engineer would be required. The matter was essentially put to rest when he was advised while en route to Elliot Lake that HUSAR/TF3 would attend with its engineer. UCRT relies on local engineers because it does not have its own on-call structural engineers.<sup>224</sup>



As a general matter from an operational perspective, Cst. Cox agreed with the role of an engineer described by Stephenson Engineering:

The primary responsibilities of the Structural Engineer are to determine stabilization requirements of a structure that are beyond the scope of the teams [*sic*] FOG [field operation guide] manual, and to monitor changes in the structure using measurement equipment. This measurement information is to be supplied to the team to aid in the team's risk assessment process. The Structural Engineer will not be required to make conclusions about the structures [*sic*] safety. It is understood that the structure is not safe. It has collapsed and may again for many reasons that would be impossible to predict. Therefore, the Structural Engineer's role is to suggest possible methods of shoring that may improve rescuers' safety.<sup>225</sup>

Insp. Jollymore provided the contact information for the local Rona store for the purpose of supplying the lumber for the emergency response.<sup>226</sup>

There was some communication between UCRT and HUSAR/TF3 as the two teams travelled to Elliot Lake. Sgt. Gillespie testified that he spoke with Capt. Tony Comella, the HUSAR/TF3 team leader from the Toronto Fire Department, two or three times, primarily to coordinate their activities and to ensure adequate access to supplies such as lumber.<sup>227</sup>

After Cst. Cox arrived in Elliot Lake, he wanted to be able to view the photographs that had been taken of the collapse site – to get a better understanding of the situation and to put a plan together. He reviewed – evidently for the first time – some of the photographs that Cst. Burns had taken of the collapse zone from the helicopter earlier in the evening.<sup>228</sup>

Cst. Cox testified that the other members of the UCRT team arrived between 9:00 and 9:30 p.m. on June 23. After his meeting with Insp. Jollymore, Cst. Cox identified a location for the other UCRT vehicles to set up their operations.<sup>229</sup>

Cst. Bailey arrived in Elliot Lake at 9:00 p.m. He was advised by a sergeant with the local OPP detachment that Cst. Cox had already arrived. He was also told that approximately 50 people were missing or unaccounted for. One of the local firefighters informed him that they had made possible communication with one victim who was trapped under the debris pile and that they could see the hand and the arm of another victim. Cst. Bailey spent the rest of the evening assisting UCRT to prepare its equipment.<sup>230</sup>

Cst. Cox testified that UCRT set up its equipment and vehicles in the parking area immediately to the south of the Foodland store. From there, as part of their initial reconnaissance, the UCRT team members began assessing the collapse area from the main entrance of the Mall. From that vantage point, they could see that pieces of the concrete slabs had fallen into the collapse area. Cst. Cox proceeded up to the second level of the Mall and looked into the collapse zone from its west side. He could see that the slabs which had fallen on the escalators were putting a lot of stress on the beam running underneath the escalators and supporting the second level. At that point, he decided that the main entrance of the building was not a safe access point.<sup>231</sup>

Subsequently, Cst. Cox and his team went onto the roof and viewed the hole from the west side of the collapse zone. There, he and his team attempted to assess the structure to ensure that it was safe to work in the area immediately around the collapse zone. They also tried to assess whether it was a good location in which to set up rope operations for the purpose of lowering people into the pile.<sup>232</sup>

Cst. Cox testified that his initial reconnaissance plan was to set up a rope operation to lower two members into the collapse zone from the roof. The lowering would take place from the west side of the hole in the roof. Cst. Cox explained that they would lower the members down with equipment including a LifeLocator device,

air-monitoring equipment, and cameras. In addition, these members would call out to the potential victims to see if they could hear any responses coming from the pile.<sup>233</sup>

Having devised his reconnaissance plan to this point, Cst. Cox returned to the main entrance of the building, where he met with Chief Officer and Dave Howse, a program specialist from the Emergency and Preparedness Response Unit of the Office of the Fire Marshal. Chief Officer advised Cst. Cox that the Elliot Lake Fire Department was there to assist UCRT and that the firefighters were going to be on standby.<sup>234</sup>

Cst. Cox explained his initial plan to Chief Officer and Mr. Howse. Shortly thereafter, Mr. Howse informed Cst. Cox that the Ministry of Labour was shutting down the UCRT operation until it assessed the structure. Cst. Cox believed that the Ministry of Labour could not shut down a rescue operation when there were still live victims who could possibly be rescued. He testified that, although he questioned whether the ministry had the authority to shut down a rescue, his team had not yet lowered anybody on the pile; there was nothing to stand down at that point. He stated that, within two to five minutes, he was advised by Mr. Howse that, in fact, no official order had been given by the ministry and that it was unclear where that information had come from.<sup>235</sup>

Cst. Cox also testified that Chief Officer agreed with the initial plan he had proposed.<sup>236</sup>

On the roof, at the same time as the rope operations were being set up, UCRT members, assisted by members of the Elliot Lake Fire Department, were working to provide portable lighting on the roof.

Sgt. Gillespie arrived in Elliot Lake at 11:35 p.m. He did not speak to Insp. Jollymore and did not know if a crane had been ordered.<sup>237</sup> He testified that, when he arrived, his first priority was to find out what was going on with his team. He learned that UCRT members were on the rooftop parking deck, so he went to that location to find out what they were doing. Sgt. Gillespie explained that when he arrived, he could see the collapsed support beam that was hanging on an angle. It appeared to him to be so rusted that it looked as though it had been "sitting outside for 20 years." He took photos of the scene and sent them to Capt. Comella. Sgt. Gillespie attempted to keep Capt. Comella informed as much as possible so that HUSAR/TF3 would be aware of what the UCRT team had been doing. He also spoke with local firefighters to gain intelligence from them about the nature of the emergency. Sgt. Gillespie testified that he was told by the firefighters that there had been some sort of verbal communication with a victim, and they identified where they thought that victim was. He further testified that the firefighters indicated an area around phone booths, in the food court area, where they believed a second person to be deceased.<sup>238</sup>



**Figure 2.3.8 UCRT members set up portable lighting on the roof of the Mall**

Source Exhibit 7925

Sgt. Gillespie testified that UCRT team members were planning to rappel down on the pile. He said he could see widow-makers (precariously hanging concrete that could fall at any moment) overhanging the collapse zone. He said he was not comfortable with the idea of team members rappelling down on the pile because there was limited access to, and egress from, the collapsed zone. If the building became unstable, there would be no way out. He was also concerned because he did not have a sense about the overall stability of the building. As a result, he wanted to get an assessment of the building before putting any of his team members into the collapse zone without a more certain escape route. He therefore ordered the team members to deploy a thermal camera in the hope of detecting a living person. Sgt. Gillespie testified that, as he expected, the thermal camera gave negative results because it had been only a few hours since the collapse. The fallen material would still have been emitting heat absorbed over the course of a warm summer's day. He stated that he also deployed air-monitoring equipment to identify any hazardous gases.<sup>239</sup>

When Cst. Cox formulated his plan, he did not factor the members of HUSAR/TF3 into the equation. His plan was a continuation of the initial reconnaissance.<sup>240</sup> He testified that he did not know if HUSAR/TF3 knew that UCRT had requested a crane.<sup>241</sup>

## 11 p.m.: The perimeter is secure

Insp. Jollymore stated he was satisfied that the perimeter of the Mall was secure by 11:00 p.m. He testified that one complication was the difficulty in securing the wooded area to the west of the Mall.<sup>242</sup> He estimated that, by approximately 11 p.m., he had close to 20 officers on site.<sup>243</sup>

## Insp. Jollymore establishes a missing persons list and a command post at the Collins Hall

Insp. Jollymore testified that another central component of his responsibilities was to identify who was in the building at the time of the collapse and to create a list of people who might be missing or still inside. He stated that the people who were in the Mall had to be accounted for, and that it was the OPP's responsibility to attempt to identify them.<sup>244</sup>

**Insp. Jollymore testified that another central component of his responsibilities was to identify who was in the building at the time of the collapse and to create a list of people who might be missing or still inside.**

In his testimony, Insp. Jollymore said that he approached the municipality and suggested that the Collins Hall, a short distance from the Mall, be set up to serve as a place for family members of victims or possible victims to gather, along with other people from the community. Victim support services would be available there. In addition, Insp. Jollymore assigned officers to that site to manage the missing persons list.<sup>245</sup>

Robin Kerr is the director of Victims Services of Algoma, a program indirectly funded by the Ministry of the Attorney General whose jurisdiction coincides with that of the East Algoma detachment of the OPP. She first learned of the Mall collapse from one of the organization's volunteers in Elliot Lake at approximately 3:00 p.m. The organization will not deploy unless it is requested by the OPP. At 4:00 p.m., the OPP requested its assistance through the Communications Centre in North Bay. At that time, Victims Services had six volunteers who could respond to this deployment. Ms. Kerr herself arrived in Elliot Lake and went to the Collins Hall at 7 p.m.<sup>246</sup>

Insp. Jollymore made a point, on June 23, of trying to go to the Collins Hall to give additional information to the people who had gathered there. He testified that he did not provide a lot of updates, but at least he or one of his officers would be there from time to time so that the people in the Collins Hall could talk to them.<sup>247</sup>



The missing persons list was constantly updated with information coming in to the OPP Communications Centre, identifying people who might have been in the Mall when it collapsed. In fact, Insp. Jollymore testified, it included people whose names had been called in but who were not even in Elliot Lake that weekend. At one point, the list had more than 100 names.<sup>248</sup> He stated that the names of Lucie Aylwin and Doloris Perizzolo were on the list from the very beginning – and remained there throughout the rescue operation.<sup>249</sup>

## The Office of the Fire Marshal and the Provincial Emergency Operations Centre

Earlier in this Report, I described the roles of the Office of the Fire Marshal (OFM) and the Provincial Emergency Operations Centre (PEOC) in the context of an evolving emergency response. I now turn to the role they played during the early stages of deployment and rescue. The PEOC is supposed to be the first point of contact for a local mayor who is declaring an emergency, or for a local fire chief who is seeking provincial assistance. The centre then contacts the operations manager of the OFM's Emergency Preparedness and Response Unit. This unit becomes the liaison with the local fire chief to discuss needs and to activate the appropriate response. It keeps the PEOC, and thereby the commissioner of community safety and others within the government apparatus, apprised of developments on the ground.<sup>250</sup>

The situation did not unfold in exactly this manner in Elliot Lake, but the result was essentially the same. The PEOC was made aware of the Mall collapse, and the Emergency Preparedness and Response Unit was quickly engaged.

### 3:26 p.m.: Chief Officer requests HUSAR/TF3 assistance

As discussed earlier, Chief Paul Officer did not contact the PEOC when he realized he needed heavy search and rescue capabilities. His notes state that at approximately 3 p.m. on Saturday, June 23, he instead tried contacting Bob Thorpe, who was a fire protection adviser with the Northeast Region of the Office of the Fire Marshal (the area encompassing Elliot Lake).<sup>251</sup> He eventually reached Mr. Thorpe at 3:26 p.m. and requested HUSAR/TF3 assistance. Following conversations with Mr. Thorpe, Chief Officer also asked his fire department dispatch to contact the PEOC to request the activation of HUSAR/TF3, even though Mr. Thorpe had told him the declaration of emergency was still necessary. Chief Officer's notes for 3:45 p.m. read as follows: "Through the calls from the OFM we were advised that the mayor will have to declare an Emergency. OFM are already moving on it anyway."<sup>252</sup>

Chief Officer agreed in testimony that the normal protocol was to contact the PEOC first. He did not do so because he thought the PEOC required a declaration of emergency before a HUSAR/TF3 team could be activated.<sup>253</sup> Not knowing how long it would take for the City of Elliot Lake to declare an emergency, Chief Officer contacted Mr. Thorpe in the meantime to have him "work the back channels."<sup>254</sup>

Once contacted, Mr. Thorpe worked through a checklist of questions with Chief Officer, including whether there had been an explosion. Chief Officer did his best to answer all the questions and then was assured by Mr. Thorpe that he would indeed work the back channels to speed up deployment of a HUSAR/TF3 team.<sup>255</sup> Mr. Thorpe conveyed Chief Officer's request up the chain. It quickly reached Carol-Lynn Chambers, the operations manager with the OFM's Emergency Preparedness and Response Unit.

### 3:36 p.m.: Province swings into action

Ms. Chambers was no stranger to the emergency response milieu. From 1992 to 2002, she held a number of positions in fire protection, including deputy fire chief for the City of London, Ontario. She joined the Ontario public service in 2002. From March 2003 to April 2006, she was operations manager of the Strategic Development Unit, Fire Protection Services, within the Office of the Fire Marshal. From April 2006 to August 2010, she was operations manager with the Emergency Preparedness and Strategic Development Unit. In February 2012, she became operations manager at the OFM's Emergency Preparedness and Response Unit (EPRU) – the position she held at the time of the collapse.<sup>256</sup>

Ms. Chambers explained her responsibilities as operations manager during an emergency. She is on-call and available 24 hours a day on a rotating basis with another individual, based in Toronto, ready to respond to requests for assistance from municipal fire departments. The typical assistance she would offer would be in the area of CBRNE (chemical, biological, radiological, nuclear, and explosives) and HUSAR/TF3 services. She is the person responsible for coordinating the provincial CBRNE and HUSAR/TF3 teams. She assesses the needs and the resources sought and, through the PEOC, deploys the necessary teams.<sup>257</sup> In addition, her role includes assisting HUSAR/TF3 with logistics and peripheral support.<sup>258</sup>

Ms. Chambers had four program specialists on staff with the EPRU and available to deploy. These specialists play a liaison role during a local emergency and provide support in areas such as the acquisition of additional equipment available through the OFM. They are not meant to provide operational assistance or be intimately involved with the operation itself. They are, instead, the link between the OFM and the emergency response scene, reporting back to Ms. Chambers in real time.<sup>259</sup>

Since 2006, Ms. Chambers has responded to approximately 60 requests for assistance from local fire departments for various types of incidents. She has also participated in most of the HUSAR/TF3 exercises, five or six in total since 2006. She has extensive Incident Management System (IMS) training, along with training in the command structures used in the firefighting milieu, similar but not identical to IMS.<sup>260</sup>

Mr. Thorpe did not communicate directly with Ms. Chambers. Instead, he appears first to have contacted Art Booth (regional manager for the OFM's Northeast Region). At 3:36 p.m., Mr. Booth, in turn, sent an email to Ms. Chambers with the following information:

Elliot lake [sic] is reporting a mall collapse Chief requesting assistance Husar  
Bob Thorpe is on his way  
District coordinator informed  
Injuries and numbers of trapped unknown.<sup>261</sup>

Ms. Chambers acknowledged this email at 3:40 p.m., noting that no request had yet come to her from the PEOC. She nevertheless requested Chief Officer's contact information and said she would also advise UCRT: "Acknowledged. No request from PEOC. Pls provide Chief's contact information for details, Art. Will also advise UCRT."<sup>262</sup> In short, even without a formal request from PEOC, Ms. Chambers took the next step, which was to contact the local fire chief for more information.

Ms. Chambers agreed that this process was unusual because she was hearing about the need for HUSAR/TF3 directly from the field, and not through PEOC. It was also coming to her by email, instead of by phone.<sup>263</sup>

Ms. Chambers, who was visiting her sister at the time, started a sequence of calls, as she had done at least 60 times before. Within a short period she had spoken to or contacted a number of people, including Chief Officer, the PEOC, the OPP duty officer, UCRT's Sgt. Gillespie, and HUSAR/TF3. She wrote the following email at 3:55 p.m.:

Spoke with Bob Thorpe who is en route. Spoke to Paul Officer (Chief) rep who indicates persons trapped, still assessing. Contacted Toronto HUSAR via Comms to notify and request deployment availability and standup time. Contacted OPP Duty Office. UCRT is en route at this time ETA 8-9 hours per duty officer. Left message with UCRT lead Sgt Gillespie on cell to contact to coordinate re TO HUSAR.

Standby<sup>264</sup>

Ms. Chambers indicated that the request for a stand-up time from HUSAR/TF3 was essentially to find out how quickly it could deploy – it was a preliminary step in notifying the team of the incident and the potential need for its assistance.<sup>265</sup> However, it was clearly her intention at this point that the unit would deploy. So, too, would UCRT. She was therefore playing the additional role of conduit between both groups.<sup>266</sup>

Ms. Chambers addressed the email to Trevor Bain (executive officer for the Fire Marshal), Shayne Mintz (assistant deputy fire marshal), and Mr. Booth. She also copied Dave Howse, who was the on-call program specialist from her own Emergency Preparedness and Response Unit at the time. By 4:10 p.m., Ms. Chambers had also deployed Mr. Howse (by phone) in order to ensure an EPRU response and presence in Elliot Lake – in keeping with the standard procedure.<sup>267</sup>

In short order, then, Ms. Chambers had deployed two OFM staff to the scene, with a third to follow soon after. The first was Mr. Thorpe, sent to monitor and report to her, and to offer assistance to Chief Officer, whom he knew from previous encounters. Mr. Thorpe would assist Chief Officer with many things, including putting the mutual aid assistance into place. Mr. Howse, as a program specialist, was sent to liaise with Mr. Thorpe but also to serve as a liaison between HUSAR/TF3 and the EPRU. Mr. Howse was to assist HUSAR/TF3 with the acquisition of additional equipment, such as lumber and respirators, and with other needs.<sup>268</sup>

Shortly after 4 p.m., the PEOC received the City of Elliot Lake's official declaration of emergency. HUSAR/TF3 already knew its services would be needed.<sup>269</sup>

Shortly after 4 p.m., the PEOC received the City of Elliot Lake's official declaration of emergency. HUSAR/TF3 already knew its services would be needed.

At 4:41 p.m, Dan Hefkey, the commissioner for community safety at the Ministry of Community Safety and Correctional Services, received a call from the duty operations chief at PEOC and was provided with information about the situation in Elliot Lake.<sup>270</sup> At 4:42 p.m., he gave verbal authorization for HUSAR/TF3 deployment. News of the approval was sent at 4:51 p.m. by PEOC to Ms. Chambers. At this stage, it was merely a confirmation of the process Ms. Chambers had already set in motion. Normally, the approval would come first and then HUSAR/TF3 would be deployed, but in this instance Ms. Chambers had expedited it, based on her understanding and experience that there would be no hesitation to approve the deployment at Mr. Hefkey's end.<sup>271</sup>



Ms. Chambers continued to play the role of information quarterback. She spoke to Chief Officer and, at 5 p.m., provided an update on the situation in Elliot Lake to a number of people, now including Ted Wieclawek, the fire marshal, and UCRT's Sgt. Gillespie:

Spoke with Fire Chief Officer confirming OPP UCRT are attending and TO HUSAR responding with as many [as] can muster immediately based on sitrep (from OPP and TO HUSAR). Chief Officer confirms a 30 x 60 ft area of collapse with one confirmed patient not accessible. Structural concerns per Chief Building Official on scene (1<sup>st</sup> floor slab hanging, 1 beam of concern).

Standby for further sitreps as info becomes available\*

At 5:18 p.m., Ms. Chambers provided an additional update to Messrs. Mintz and Bain and the fire marshal, along with others in the OFM including Messrs. Howse and Thorpe. Added to the list was Dan Newburn, who would be the third staff person from the OFM to deploy to Elliot Lake. In addition to speaking to Chief Officer, Ms. Chambers spoke by phone to the OPP UCRT team lead, HUSAR/TF3 team lead, Toronto Fire Services "Comms," and the PEOC. She then sent the following message, typical of how she would report up the chain within her department:

Commercial mall 30 x 60 area affected. 1 confirmed patient, currently inaccessible per FC Officer (Elliot Lake).

TO HUSAR contacted via TO Comms and put on notice for deployment.

OPP UCRT responding 8–9 hrs out from deployment time. 10 members plus 2 medics. Requesting TO HUSAR support.

TO HUSAR confirms response with available personnel # TBA per Staff Insp Neadles as confirmed with TFS Chief Jenkins and Team Lead Comella.

Declaration of emergency received confirming request for HUSAR.

OFM staff responding: Thorpe, Howse, Newburn

...

Further info to follow as received. Continuing to monitor.<sup>272</sup>

Ms. Chambers also liaised with HUSAR/TF3's Staff Insp. Neadles. At 5:25 p.m., she wrote to him to get an estimate of how many members would deploy and the "wheels-up" time of departure. At 5:31 p.m., she wrote to him again, with a description of the collapse scene: "FC [Chief Officer] says 30 x 60 area involved. Lots of concrete. 1 person suspected viable but not accessible. 2nd potential."<sup>273</sup> With this message, Ms. Chambers was providing Staff Insp. Neadles, still in Toronto, with his first bit of detailed information about the collapse site and victims.<sup>274</sup>

At 6:08 p.m., the PEOC released its first Emergency Information Notification about the collapse. It was sent out by the duty operations officer to the people on the Emergency Management Ontario listserv – a list internal to the government and meant to inform those who needed to be involved in or aware of the emergency situation. While the notification did provide information about the Elliot Lake response, it was more of a general nature and clearly not intended as a guide to rescue workers on the ground and those assisting them. The notification read as follows:

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\* Exhibit 6441. Around this time, Ms. Chambers sent the same update to Pierre Yelle, who was the on-call manager for a different unit within the Office of the Fire Marshal. Ms. Chambers foresaw that the Elliot Lake deployment would be lengthy, and she kept him informed because she would likely need his assistance. Ultimately, Mr. Yelle did cover for her while she rested: Exhibit 6443; Chambers testimony, September 18, 2013, pp. 26109–10.

**Description of Threat/Event:**

At 2012-06-23 1509 the PEOC was advised of a structural collapse that had occurred at approximately 2012-06-23 1415 involving the roof of a three storey shopping mall ('Eastwood Mall') located at 151 Ontario Street in Elliot Lake. At least one person is trapped in the debris. Although other people have been injured, current reports indicate these individuals are mobile and their treatment is within the capacity of local medical services.

**Source of Reporting:**

- Elliot Lake Fire
- OFM
- OPP

**Current Actions:**

- Local Police, Fire and EMS have responded to the scene.
- The community has declared an emergency and formally requested HUSAR assistance. This request has received Provincial approval.
- OFM EPSD is currently liaising directly with Toronto Fire Service regarding deployment of HUSAR resources in support of this event. Toronto HUSAR deployment plan currently in process. Specific details and ETA to follow.
- OPP UCERT is deploying 10 members and 2 medics from Bolton to Elliot Lake (ETA approximately 2012-06-24 0000)
- OFM is deploying 3 members to the scene (first ETA approximately 2012-06-23 1730).

**Initial Analysis/Assessment**

- All stakeholders are actively engaged in providing an appropriate level of response as quickly as possible.
- The PEOC continues to closely monitor the situation should there be additional requests for Provincial support.<sup>275</sup>

The PEOC would continue to send out notifications of this type at regular intervals throughout the emergency response. These notifications clearly served to keep concerned people within the government apparatus informed of developments, but I saw no evidence to indicate that they were of any practical assistance in keeping rescue workers at, or heading to, the scene informed. Again, Ms. Chambers appeared to play the most active role in keeping those parties informed in real time of events on the ground in Elliot Lake, at least during the early stages of deployment.

At 6:17 p.m., Ms. Chambers and others with the OFM were aware that Chief Officer had pulled his firefighters off the pile. Mr. Thorpe sent an email stating: "Update ... due to unsafe conditions of the structure all responders are evacuating the building. There is one confirmed VSA [vital signs absent]."<sup>276</sup>

Mr. Thorpe was also present at the 6:30 p.m. Community Control Group meeting in Elliot Lake that day. He was the first provincial attendee.<sup>277</sup> He reported back to Ms. Chambers at 7:36 p.m. on the results of the meeting, advising that the operations would be suspended until the arrival of both HUSAR/TF3 and a structural engineer to assess the structural integrity of the building. He added that nine people were unaccounted for and that 17 had reported to the hospital emergency department.<sup>278</sup>

At the same time, Ms. Chambers again acted as a conduit of information between HUSAR/TF3 and UCRT. She sent an email to Staff Insp. Neadles following a conversation with Sgt. Gillespie:

10-4. Just spoke to Jamie Gillespie from the OPP UCRT. Based on their sitrep, most urgent need is a structural engineer which they don't have in Elliot Lake, a heavy crane for removing the large slab(s), and a relief crew from TO HUSAR early morning. He and I agree that best to send what you have now, with that in mind, rather than await 65 or 70 which could delay any response. Wheels up time?<sup>279</sup>

Staff Insp. Neadles had just conveyed to Ms. Chambers that the team had about 34 members ready to go. Following Ms. Chambers's suggestion that the team deploy with those numbers, Staff Insp. Neadles immediately wrote back to say that members were loading the tractor trailers and aiming for an 8:30 p.m. departure.<sup>280</sup> Ms. Chambers soon learned that HUSAR/TF3 was bringing its own engineer, and abandoned efforts to find one elsewhere.<sup>281</sup> At 7:42 p.m., she also conveyed the news of the departure time to Mr. Thorpe and Mr. Howse and even suggested to them that OFM might assist with local inquiries for a crane, given the information she had that Sgt. Gillespie was anticipating the need for one.<sup>282</sup>

At 7:57 p.m., Ms. Chambers wrote to Sgt. Gillespie, copying Staff Insp. Neadles. She advised UCRT of HUSAR/TF3's departure time, and also of the fact that Messrs. Thorpe and Newburn had arrived at the scene and were providing local liaison. Mr. Howse was en route with additional radios and lighting. She also provided Sgt. Gillespie with photos of the scene taken by Mr. Thorpe.<sup>283</sup>

At 8:22 p.m., Insp. Neadles wrote to Ms. Chambers to say that "wheels up" time had been pushed back another 30 to 60 minutes because of a delay with the tractor.<sup>284</sup>

At approximately 8:30 p.m., Ms. Chambers spoke to Chief Officer at the scene. Although he had pulled his firefighters from the scene for safety reasons, he wanted to do all he could for anyone who was trapped. Ms. Chambers said she would put him in direct contact with UCRT's Sgt. Gillespie.<sup>285</sup>

At 9:15 p.m., Ms. Chambers sent a detailed update to people within the OFM and the PEOC, and to Sgt. Gillespie at UCRT. The message included reference to the fact that Mr. Thorpe was finalizing accommodation for the teams that were en route<sup>286</sup> and also looking into the provision of meals. These arrangements were part of Ms. Chambers's responsibilities at the OFM, so that the rescue workers could focus on operations.<sup>287</sup>

By the time of the Community Control Group meeting at 10:05 p.m., the Office of the Fire Marshal was well represented. Messrs. Newburn, Howse, and Thorpe were all present.<sup>288</sup>

At 11:16 p.m., Ms. Chambers sent another internal update to the OFM. At 11:31 p.m., she forwarded it to Sgt. Gillespie and Staff Insp. Neadles. The update indicated, among other things, that UCRT was now on scene with 13 members and was either in the process of being briefed, or had been briefed, by the Elliot Lake Fire Department incident commander.<sup>289</sup>

Ms. Chambers continued to be the main source of information for Staff Insp. Neadles, who told the Commission that, up to this point (11:16 p.m. on June 23), he had not had contact with Sgt. Gillespie except indirectly through her.<sup>290</sup>

At 11:35 p.m., Mr. Neadles wrote to Ms. Chambers asking her for more pictures and floor-plan drawings. Ms. Chambers forwarded the request to Messrs. Howse and Thorpe. She also told them to convey locally that HUSAR's estimated time of arrival was now 4 a.m.<sup>291</sup>

A short time later, Ms. Chambers interacted with Staff Insp. Neadles and OFM staff about the role of the Ministry of Labour at the rescue site. I discuss that issue later in the chapter.



The preceding paragraphs have described the important role of the Office of the Fire Marshal, and in particular of Ms. Chambers, as a liaison between provincial resources and the local response during an emergency. I find the OFM's involvement to have been efficient, focused, and useful.

**The preceding paragraphs have described the important role of the Office of the Fire Marshal, and in particular of Ms. Chambers, as a liaison between provincial resources and the local response during an emergency. I find the OFM's involvement to have been efficient, focused, and useful.**

I am somewhat troubled by the fact that Chief Officer felt he could not contact the PEOC to request HUSAR/TF3 services until the City of Elliot Lake formally declared an emergency. In this instance, it was not important because Ms. Chambers facilitated the process and no time was lost. I worry, though, that this requirement might cause unnecessary delay and confusion during future missions. It should be made clear to local emergency responders that they should never hesitate to send the request to the PEOC, even if a formal declaration of emergency has not yet been issued.

There is little to say about the role of the PEOC as an information conduit.

That role appears to me to be higher level, of assistance to the larger government infrastructure but not to the rescuers at the scene.

## Ministry of Labour deployment to the rescue scene

### 6:40 p.m.: Ministry of Labour sends a structural engineer to Elliot Lake to provide assistance

At 4:35 p.m., Mr. Hefkey spoke to Sophie Dennis, an assistant deputy minister with the Ministry of Labour (MOL). He informed her of the structural collapse, that some people had been injured, and that others, possibly, were still trapped. He told her it might be wise to have a member of her staff go to Elliot Lake.<sup>292</sup> At the time, Mr. Hefkey's only expectation was that the MOL worker would investigate the circumstances leading to injury. He did not suggest that Ms. Dennis send a structural engineer.<sup>293</sup>

At 5:03 p.m., the Premier's Office also contacted the Ministry of Labour. Fahim Kaderdina, the chief of staff,<sup>294</sup> and another individual from the ministry were copied on email correspondence about the collapse and the response.<sup>295</sup> Mr. Kaderdina wrote to John O'Leary of the Premier's Office at 5:34 p.m., saying: "First responders call in MOL when necessary. Right now, no MOL presence on site. Will let you know if that changes."<sup>296</sup>

At 5:46 p.m. on June 23, Ms. Dennis contacted Roger Jeffreys, the provincial engineer with the ministry.<sup>297</sup> She told him there had been a mall collapse in Elliot Lake, someone was trapped under the rubble, and a structural engineer was needed.<sup>298</sup>

Mr. Jeffreys called all four of the MOL structural engineers available in Ontario. He had difficulty reaching any of them: MOL engineers are not on call, nor are they paid overtime. He called an engineer in Brampton, who did not answer. Another was on vacation. A third was busy investigating a stage collapse causing death. The fourth, Brian Sanders,\* from London, did call him back, but was not immediately available because of family commitments. He said he would go to Elliot Lake the following day.<sup>299</sup>

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\* I also discuss Mr. Sanders's qualifications in the next section. Mr. Sanders went to Elliot Lake the following day: Sanders testimony, October 4, 2013, pp. 28277–80.

Ms. Dennis had not initially provided specifics on what she expected the structural engineer to do at the scene of the collapse. Mr. Jeffreys thought the structural engineer was needed only to assist MOL inspectors with an investigation into the cause of the collapse and the injuries. However, when he called Ms. Dennis back at 6:40 p.m. to say that he was the only engineer available to deploy, he received what he described as “very unusual” instructions. Ms. Dennis told him to go to Elliot Lake and provide whatever assistance he could:

... So I called Ms. Dennis back and explained there was no structural engineers available except myself. I told her she was scraping under the barrel, and I said I don't usually go to the field. In fact, my manager doesn't want me in the field, and her instruction was [for] me to go. And she said something very unusual. She said, “I want you to go. I want you to sister up with the organizations that are there, and I want you to give them whatever help you can.”<sup>300</sup>

Mr. Jeffreys therefore understood he was going to Elliot Lake not for enforcement of the *Occupational Health and Safety Act* but to assist in his capacity as a structural engineer. He did not question the order. From his point of view, human lives were at stake, and he had been asked to help.<sup>301</sup>

Mr. Jeffreys was in Brantford when he received the call. He did not leave Brantford until approximately 7 p.m. on June 23.<sup>302</sup> He arrived at the Elliot Lake OPP detachment at 12:30 a.m. on June 24, where he met with two Ministry of Labour inspectors and went to the collapse site.<sup>303</sup>

## 6 p.m. and 7:15 p.m.: Ministry of Labour inspectors are sent to Elliot Lake to investigate the collapse and the missing workers

At 5:35 p.m., Martinette Venter, the owner of the Shoppers Drug Mart in Elliot Lake and the lottery ticket kiosk where Ms. Aylwin worked in the Mall, called the MOL to report that a worker (Lucie Aylwin) was missing.<sup>304</sup> Employers are required under the *Occupational Health and Safety Act* to report fatalities and critical injuries. An inspector is then dispatched to the scene to gather information and begin an investigation into the cause. Donald Jones and Michel Lacroix were the inspectors dispatched in response to this call.\*

Mr. Jones was contacted around 6 p.m. on June 23 by Don Jewett, the MOL regional manager. He was asked to go to Elliot Lake because there had been a partial collapse of a mall, but was not given specific instructions on what to do. The MOL investigates occurrences such as this one, and he felt he knew what to look for. However, he had never been to a structural collapse similar to the Elliot Lake Mall collapse, and he did not know what he would be facing on arrival.<sup>305</sup>

Mr. Lacroix was contacted by the same regional manager who contacted Mr. Jones, at approximately 7:15 p.m. Mr. Lacroix did not receive any particular instructions, other than to assist Mr. Jones with the investigation. He understood there was one fatality and that he was going to Elliot Lake to investigate the root cause of the collapse. He was not told that he would attend the scene to oversee or participate in a rescue operation. From his point of view, he was doing what he typically did – deploying in short order to the scene of a fatality at a workplace.<sup>306</sup>

Although it seems that the genesis for the deployment of the two inspectors was the call from Ms. Aylwin's employer, Messrs. Jones and Lacroix were soon aware that Mr. Jeffreys had also been dispatched. The inspectors were instructed to go to the OPP station in Elliot Lake and wait for him there.<sup>†</sup>

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\* Jones testimony, September 26, 2013, pp. 27428–9. I discuss the background and credentials of these individuals in the next section.

† Exhibit 6385; Lacroix testimony, October 3, 2013, pp. 27963–9. Interestingly, Ed Hudson, the MOL inspector who had inspected the Mall in the months before the collapse, was the inspector actually responsible for the Elliot Lake region and on call that day. According to Mr. Lacroix, Mr. Jewett had contacted Mr. Hudson but, because he was about to retire, Mr. Hudson asked that someone else be assigned: Lacroix testimony, October 3, 2013, pp. 28030–1.

Messrs. Jones and Lacroix arrived in Elliot Lake at approximately 10:30 p.m. and went to the OPP detachment as planned.<sup>307</sup> They waited there for Mr. Jeffreys, as instructed, and did not go directly to the scene of the collapse.<sup>308</sup>

## Ministry of Labour confusion about its role at the scene of a rescue

In this section, I discuss the background and qualifications of the Ministry of Labour staff deployed to the collapse, the role of provincial and regional engineers within the MOL, and the understanding the MOL engineers and inspectors who went to Elliot Lake had about their respective roles at the scene of an ongoing rescue. This latter question was the source of much confusion, both for the ministry staff deployed and for the rescue workers at the scene.

### Background and responsibilities of the MOL engineers

Mr. Jeffreys graduated from Queen's University in 1966 with a bachelor's degree in applied science and a specialization in civil engineering, a subset of which included structural engineering. He had a long career in the private sector before joining the MOL. From 1966 to 1970, he worked for a company doing structural design work. From 1970 to 1987, he worked first for General Electric and then for Atomic Energy of Canada Limited (AECL) at a heavy-water manufacturing plant in Cape Breton. He held numerous positions over the years, starting out as a project and commission engineer, then head of planning, manager of engineering and maintenance, operations manager, and, finally, general manager of the entire plant.<sup>309</sup>

Mr. Jeffreys's work with AECL involved structural engineering on a continuous basis until the late 1970s, including structural design and structural assessment (looking at why buildings failed). He was sent on one occasion to look at a 500-foot flare tower to examine a structural failure and determine how workers could safely carry out repairs. On another occasion, he assessed damage to a collapsed tower. With the help of confined-space rescuers, he tunnelled down 6 to 7.5 metres into the rubble to assess the situation and develop a plan for safe repair. Structural engineering continued to be relevant to his work in managerial positions at the plant. For a period of time, he was responsible for approving structural design and maintenance engineering work, including rigging, in a work environment containing highly toxic, flammable, and potentially explosive substances. As he put it: "[E]verything had to be done precisely, including the removal of every piece of maintenance equipment in that plant."<sup>310</sup> In short, Mr. Jeffreys, at least in the early part of his career, was no stranger to structural engineering and associated safety issues, including working together with rescuers, using cranes, and overseeing engineered procedures to move heavy equipment.<sup>311</sup>

Mr. Jeffreys left AECL in 1987. He worked first as a plant manager and then ran his own business from 1990 to 2004 as a management and engineering consultant. This period of his career involved very little structural engineering work, other than a certain amount of demolition consulting early on.<sup>312</sup>

In December 2004, Mr. Jeffreys joined the Ministry of Labour as an occupational health and safety inspector. He worked in that capacity for three years until, in 2007, he was promoted to the position of regional engineer. In 2010, Mr. Jeffreys became the provincial engineer.<sup>313</sup> In his testimony, he explained that regional engineers are allocated to the various regions in Ontario. When he held this position, he covered the area west of Mississauga and part of southern Ontario. However, because there were only three structural engineers in the ministry for the whole province, he would often be asked to deploy to other areas. The other regional engineers had mechanical, chemical, and mining specializations.<sup>314</sup>

**When Mr. Jeffreys held this position, he covered the area west of Mississauga and part of southern Ontario. However, because there were only three structural engineers in the ministry for the whole province, he would often be asked to deploy to other areas.**



As a regional engineer, with his specialty in structural engineering, Mr. Jeffreys's duties usually involved assisting MOL inspectors who, after inspecting a workplace, felt they had identified and required assistance with assessing a structural issue. Mr. Jeffreys would be called to the workplace in question to determine whether the structural issue was significant and created safety concerns. He might also attend in response to a collapse, such as one occurring during the construction process. In these instances, he explained, if he identified a safety issue for the future, he would require an engineering plan to make the area safe again and assess the reasonableness of the proposed plan. During his time as regional engineer, he visited close to 100 structures that had collapsed or were in the process of collapsing, or about which the inspectors were concerned.<sup>315</sup>

Mr. Jeffreys explained that MOL engineers are designated inspectors and have the same powers as an inspector under the *Occupational Health and Safety Act*. The engineers do not tend to issue orders, though some of the MOL mining engineers in the North inspect the mines themselves and do issue orders. Typically, however, engineers accompany the inspectors, who issue the orders. One reason is that engineers are limited in number and do not usually have the time to follow up on compliance and paperwork, as an inspector would.<sup>316</sup>

**Mr. Jeffreys explained that MOL engineers are designated inspectors and have the same powers as an inspector under the *Occupational Health and Safety Act*.**

In April 2010, Mr. Jeffreys became the provincial engineer and continued to hold that position at the time of testimony. The province has one provincial engineer, whose functions include the coordination of the activities of the regional engineers in the province, training, preparation of documentation, and the creation of a uniform approach to engineering matters. The provincial engineer's office also prepares guidelines for workplaces and for the public, and prepares engineering data sheets and answers to technical questions for the various

engineering programs: mining, construction, industrial, and health care. Although the role of the provincial engineer on paper is chiefly supervisory, in practice Mr. Jeffreys has gone out into the field on occasion, to mentor and train but also, as occurred in Elliot Lake, for actual field work.<sup>317</sup>

The other MOL engineer to go to the Algo Mall collapse was Brian Sanders. He graduated from the University of Western Ontario in 2001 with a bachelor of engineering, majoring in civil engineering with a structural option. He has been a professional engineer since 2005. He worked for a structural engineering firm on industrial, commercial, and agricultural buildings for two years. He then joined an engineering consulting firm, again in the field of structural engineering, for approximately seven more years. He joined the Ministry of Labour as a regional engineer in the western region in 2009. At the time of the collapse, he was one of only four MOL structural engineers.\*

Before his involvement at Elliot Lake, Mr. Sanders had investigated about a dozen collapsed buildings.<sup>318</sup>

## **Background and responsibilities of the Ministry of Labour inspectors**

Mr. Jones was an industrial inspector. Before joining the MOL, he worked in maintenance at a steel mill in conjunction with millwrights, riggers, ironworkers, and welders.<sup>319</sup>

Mr. Lacroix was also an industrial inspector, but cross-trained for the construction milieu. He joined the ministry in 2004. His previous experience included work as an electrician with Algoma Steel in Sault Ste. Marie from 1979 to 1987.<sup>320</sup>

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\* Sanders testimony, October 4, 2013, pp. 28268–70. Mr. Sanders told the Commission that the ministry was currently in the process of hiring more structural engineers.

As industrial inspectors, Messrs. Lacroix and Jones were responsible for all workplaces, with the exception of construction projects, new construction demolition, and mine sites. As Mr. Lacroix put it, they inspected a wide variety of workplaces in the province, large and small, including “corner stores, schools, retail stores, factories, tool mills, steel plants, paper mills, [and] hospitals.”<sup>321</sup>

### **MOL engineers expressed uncertainty about their role during rescue and recovery operations**

Mr. Jeffreys had never before received training on safe rescues in a collapse situation, nor had he ever trained with HUSAR/TF3 or UCRT before his involvement in Elliot Lake. He had, however, worked with UCRT on a previous occasion when he was asked to assist during the response to the 2011 Woodstock fire and explosion. He had also been involved in an incident where rescue workers were looking to recover a body from a collapsed building, and his advice had been sought and provided.

Mr. Jeffreys told the Commission that, while it happens, it is not typical for MOL inspectors and engineers to be present at a rescue or recovery operation in a collapsed structure. The victims have usually been removed before the MOL staff arrive, and the scene has usually been turned over to the coroner. It does happen on occasion that the MOL staff arrive and the victim is still inside. In such an instance, Mr. Jeffreys felt that the MOL engineer’s primary role was to assist the overall MOL investigation. In the past, however, he has gone the extra step and provided suggestions on how to extricate victims safely. Prior to Elliot Lake, he had never given advice of this nature in a situation where a live person was trapped.<sup>322</sup>

In his testimony, Mr. Jeffreys described the assistance he provided during the response to the Woodstock fire and explosion in 2011. The local fire chief had sent a request to the MOL to have an engineer go to the scene. The western region where Woodstock was located did not have a structural engineer, and the structural engineer in Toronto could not attend immediately. Mr. Jeffreys went instead.<sup>323</sup>

Mr. Jeffreys could not clearly describe the role he played in Woodstock. He was there to assist the MOL inspector, once that person arrived, but also to help the fire chief, who had asked for assistance:

A. I went there to support an inspector in an investigation, and I was asked to go around the site by the Fire Chief, and I had no problem doing that.

Q. But what role did you see yourself performing when the Fire Chief asked you to go around? What were you there for?

A. I was there to do an investigation. He asked me to do something else.

Q. What did you understand you were doing for him?

...

A. To see if I could see any issue with what they were doing from a safety perspective.

Q. Thank you. And did you understand at that time that your role was to determine whether that particular workplace where the UCRT members were working was safe?

A. Oh, I knew the workplace wasn’t safe.

Q. So what was your role?

A. ... he asked me to look to see if I had an issue with what they were doing, whether it was a reasonable approach, and I did not have an issue with that.

Q. Reasonable approach from what perspective?

A. Well, were there risks that I could see that perhaps he hadn’t seen? That’s all I can suggest he was asking me to do.<sup>324</sup>

When he arrived at the scene of the Woodstock explosion, Mr. Jeffreys reported to the fire chief. The centre portion of a building had blown up completely. The southern section was still standing but had sustained significant damage. Mr. Jeffreys understood it to be a recovery operation with the intent to send in a search dog to look for bodies in the building.<sup>325</sup> I did not hear the details of the advice Mr. Jeffreys gave on that occasion.

Mr. Jeffreys described another situation where he was present at the scene of a recovery and provided advice to the rescue workers on how to proceed safely. Again, the situation involved the attempt to recover a deceased person. The victim had been pinned by two large and heavy concrete blocks used as retaining walls. Mr. Jeffreys noticed that the rescue workers were going to move one of the blocks in a manner that could possibly have caused further trauma to the deceased's body. He also noticed that the intended manoeuvre could potentially create a secondary collapse which could have injured the rescue workers. He pointed out the danger to the rescue workers, who revised their approach.<sup>326</sup>

After providing these two examples of previous involvement at a recovery scene, Mr. Jeffreys was asked to expand on how he perceived his role in such situations. If the rescue workers had ignored his advice about the secondary collapse, would he have issued an order under the *Occupational Health and Safety Act* to stop them? He replied that he would at least have threatened to do so:

- Q. And in that circumstance, if after you gave them your views, the workers ignored your views and decided to continue, would you have felt it appropriate to issue an order under the Act to prevent them from doing that?
- A. If they were going to continue to place themselves in harm's way under a structure that was going to fall on them, I would've been definitely more positive and would've suggested that that's what I would do.<sup>327</sup>

In essence, Mr. Jeffreys told the Commission that MOL engineers and inspectors at the scene of a recovery operation might indeed intervene to stop recovery efforts perceived as dangerous. He even agreed with the suggestion put to him that his role at a collapsed building with a deceased victim was essentially the same as at a regular workplace.<sup>328</sup>

Mr. Jeffreys was also questioned on how he perceived the role of the MOL at the scene of a rescue (ongoing attempts to save a living person) as opposed to a recovery (attempts to extricate a deceased person). At a rescue, he stated that the *Occupational Health and Safety Act* did not explicitly indicate a modified role for the MOL. He did, however, conduct his own exercise in statutory interpretation and suggested that, because the Act contains provisions saying that first responders cannot refuse unsafe work, there was an "implied statement" that unsafe work can take place and that MOL inspectors or engineers would speak up only if something was "patently unsafe." As he explained:

So there is an implied statement here that unsafe work may take place, and the inspector has to recognize that or the engineer has to recognize that. And so the inspector or engineer would not step in and issue orders to stop a rescue operation. If they saw something that was patently unsafe for one of those first responders, they would bring it to the attention of that responder's supervisor or to the responder's attention if he couldn't get anybody else in time, but that's what would normally take place.<sup>329</sup>

On the day of the collapse, Mr. Jeffreys testified, he had this same understanding of the MOL's role at a rescue operation. He had formulated it not on the basis of any training he had received with respect to rescue situations or conversations he had with other engineers and inspectors, but based on his own understanding of the *Occupational Health and Safety Act* and the training he had received on the powers of an inspector. The Act gives



inspectors the power to issue stop-work orders in a rescue situation, but in his opinion it wouldn't be reasonable for the ministry to stop a rescue:

Somebody's trying to save somebody's life, and, you know, the occupational health and safety inspector or engineer, we're all about protecting people's lives and their safety. So if somebody is being rescued, well, it's important that that move forward unimpeded.<sup>330</sup>

Mr. Jeffreys went on to add, though, that while he felt it was acceptable for rescue workers to subject themselves to a higher risk during a rescue situation,<sup>331</sup> there was a point along the spectrum of risk at which he would issue a stop-work order. For example, he would do so if four first responders' lives were clearly in danger:

THE COMMISSIONER: But bottom line, if you had a fundamental disagreement with the supervisor and if you had spoken to him, and he says, "No. We're going to do it anyway," and you say, "But that's crazy. You're risking the lives of" – let's say, for example, four first responders, ultimately you could, nevertheless, stop the work – issue a stop order?

[Mr. Jeffreys]: You're quite correct, and I would honestly hope, Mr. Commissioner, that that position would never come up.<sup>332</sup>

After giving this evidence on when he would or would not intervene in a recovery or rescue situation, Mr. Jeffreys was also asked to compare the role of an MOL engineer at a rescue or recovery scene to the role played by the engineer who accompanied HUSAR/TF3 (James Cranford). He was read the following description of the HUSAR/TF3 engineer's role:

The primary responsibilities of the Structural Engineer are to determine stabilization requirements of a structure that are beyond the scope of the teams [*sic*] FOG manual, and to monitor changes in the structure using measuring equipment. This measurement information is to be supplied to the team to aid in the team's risk assessment process. The Structural Engineer will not be required to make conclusions about the structures [*sic*] safety. It is understood that the structure is not safe. It has collapsed and may again for many reasons that would be impossible to predict. Therefore, the Structural Engineer's role is to suggest possible methods of shoring that may improve rescuer safety.<sup>333</sup>

Mr. Jeffreys felt the description was "probably a little more extensive than what I would have expected one of our Ministry of Labour engineers to do."<sup>334</sup>

Mr. Jeffreys told the Commission that he struggled with determining the appropriate role for MOL engineers at rescue and recovery operations. The situation is rare. He pointed out that he was probably the only MOL engineer to have ever been sent to the scene of an active rescue. Since the Elliot Lake deployment, HUSAR/TF3 and UCRT have both asked him if MOL engineers could train with them. The following passage is illustrative of the confusion he felt about the appropriate role for MOL engineers at a rescue, and the role he ended up playing in Elliot Lake:

Q. Would you expect the MOL engineer to give advice to the rescue workers?

A. If they wanted advice, I would ... hope that they would give the advice. I mean, this is an area that I'm struggling with right now, thinking about this very matter, because I know that the HUSAR team and the UCRT team both have asked me if I would ... have our engineers trained with them so that they can assist more on structural collapses. And I know for a fact that if our engineers were trained and I was to ask them to ... go to a rescue situation, none of them would refuse.

They are professional, and they would offer their services. However, I must say that I'm now struggling with the issue of whether or not I would want to put them in that position, having gone through this situation myself.

I really am struggling as to whether that is something that I can do –

Q. And why is that?

A. – down the road. I don't think any of us have an issue with answering the questions as to why we've reached certain decisions or why we did certain things or the advice we gave. I think all of us can stand up and say that, but I think that this process has been an extremely arduous process, a stressful process for me. And I now have to ask myself: Do I want to put my engineers in a position of having to do that? And it's something that I'll have to struggle with and talk to my management and come to a conclusion about.

THE COMMISSIONER: Are there considerations involving legal responsibilities?

THE WITNESS: Exactly, yes. I mean, our position in the Ministry has been that our engineers are not to give advice. That is our position: That they don't give advice as to how to meet compliance. They tell the workplace parties what has to be complied with. The inspector issues the order and says, "That machine has to be guarded."

The engineer does not step in and say how it is to be guarded.

Our legislation is results oriented. You guard it. You prevent worker access to it. We don't tell them how. It's not prescriptive. So we advise our engineers, "Don't give advice on how to do it. That could lead you into a legal situation down the road."

I was asked to step beyond those bounds and come here and assist in whatever way I could, foreign territory. And now I'm considering very strongly whether I'd ask our engineers to be in my shoes.<sup>335</sup>

Mr. Sanders, for his part, had never been involved with a rescue, nor had he received training related to extricating people from collapsed structures or the proper exercise of MOL authority in a rescue or recovery situation. At the time of the collapse, he understood that the MOL had jurisdiction over a rescue or recovery operation, just as it has jurisdiction over any workplace. The *Occupational Health and Safety Act* takes precedence over all other legislation. He therefore understood that the MOL had the jurisdiction to stop a rescue or

a recovery operation, but he had never faced the situation before his involvement at Elliot Lake. At the time of the rescue, he held the view that the decision about whether to intervene to stop a rescue was a discretionary one to be made by the ministry inspector.<sup>336</sup>

Like Mr. Jeffreys, Mr. Sanders felt the proper approach, if he saw something unsafe during a recovery operation, would be to bring the unsafe situation to the attention of rescue personnel. He was not asked what he would do if his advice was ignored, and he did not provide suggestions for how the situation might differ in the context of an ongoing attempt to save a living person.<sup>337</sup>

Having heard the evidence from Mr. Jeffreys and Mr. Sanders, it is clear to me that there is significant confusion about almost all aspects of the role of MOL engineers at rescue and recovery situations. When can they be called in? What type of advice do they provide the rescue workers? What are the limits, if any, to their authority? These are important questions that must be clarified

for future operations. As I discuss below, the role of the MOL was a source of significant confusion, and even a certain amount of delay, during the Elliot Lake rescue operation.

Having heard the evidence from Mr. Jeffreys and Mr. Sanders, it is clear to me that there is significant confusion about almost all aspects of the role of MOL engineers at rescue and recovery situations. When can they be called in? What type of advice do they provide the rescue workers? What are the limits, if any, to their authority?

### **The MOL inspectors attended the scene to investigate but also felt they had a role to play in bringing dangerous situations to the attention of rescue workers**

Messrs. Jones and Lacroix were also questioned about their role in Elliot Lake and how they would act if they observed rescue workers in a dangerous situation. Similar to the engineers, the MOL inspectors had never been trained on how to exercise their powers pursuant to the *Occupational Health and Safety Act* at the scene of a rescue or recovery. Both were hesitant to intervene in a rescue situation but also at a loss to define how and when it would be appropriate to do so.

Mr. Jones's understanding was that he was being dispatched to the Elliot Lake scene in order to investigate a critical injury or a fatality. He was sent, as was always the case, to verify what had happened, gather information, and begin an investigation into the cause of the occurrence.<sup>338</sup> Clearly, he saw these three tasks as his primary role.

Although trained in the provisions of the *Occupational Health and Safety Act*, Mr. Jones did not have any specific training on the safety risks associated with a rescue or a recovery operation. Given the rescue workers' greater relative expertise, Mr. Jones said he would "only note very, very obvious hazards." While he believed that, "technically," MOL inspectors have the authority to intervene in or stop a rescue if they see something unsafe, he said: "[T]his was not the case in Elliot Lake. The rescue people on-site were doing good work." He had no intention of shutting down the rescue there.<sup>339</sup> His answer implied, however, that he felt he had the power to do so.

Mr. Lacroix, also trained in all facets of the *Occupational Health and Safety Act*, said he had no specific training on the role and powers of the MOL at the scene of an emergency. He had never received instructions to oversee a rescue operation and, before Elliot Lake, had never been present as a MOL inspector during a rescue. Mr. Lacroix's understanding, like Mr. Jones's, was that the MOL, pursuant to the *Occupational Health and Safety Act*, has authority at a rescue operation, but he said he "would not interfere with any rescue operations because they are there to save lives." His personal opinion was that "the goal is to save a life and if there is any thought of someone being alive ... I am not prepared to stop something to take away someone's life. It's not my role as a Ministry of Labour inspector."<sup>340</sup>

Mr. Lacroix described the approach he would take if he saw a severe hazard for rescue workers during an attempt to save a life or recover a body. He felt the powers of the MOL were the same whether at a rescue or a recovery. It was all a matter of discretion. Nothing in the Act or the regulations existed to guide him other than his professional code of conduct requirement to act with integrity, professionalism, and honesty. His approach, if he saw something dangerous, would be to bring it to the attention of the commander, and his expectation was that he would not need to do anything further because his advice would be heeded:

Say we found something that was a severe hazard that could endanger a rescue worker, what I would do is I would go to their Commander and make them aware that – let's take for example ... at the mall itself, there was widow-makers, cement blocks, if one started to dislodge, I would inform the Incident Commander, them being professionals saying: This block is loosening up, you may want to look out for it. They are professionals. They know their capabilities and qualifications and I would be very confident that they would take the proper actions to remove their person from that area, where I don't think I would have to go in and actually tell them what to do.<sup>341</sup>

Interestingly, Mr. Lacroix said that when he arrived on the scene at 12:43 a.m. on June 24, it was clear to him that it was a rescue situation. Although he said his role was to investigate, he saw some role for himself in overseeing the health and safety of the rescue workers. He did, however, show a degree of uncertainty about the scope of his role:

Q. So you know it's a rescue that's going on?

A. Yes.

Q. At that point, what did you think your role was?

A. At that point my role would have been to, again, the health and safety and our investigation.

Q. The health and safety of what?

A. Of the workers, I apologize.



Q. Which workers?

A. Of the rescue workers, overall, just overseeing, making sure that – not making sure but just that nobody got hurt indirectly, but the biggest part of my role there was our investigation, to gather information for the investigation.

Q. But upon learning this was a rescue, you made a determination that you also had a role to serve as an inspector to oversee the health and safety of the workers; is that right?

A. ... at that point it was more of looking to see what went on and gather information for our investigation.<sup>342</sup>

It is clear to me that MOL inspectors, like MOL engineers, are also uncertain about their role and jurisdiction at rescue and recovery operations. Both roles must be clarified.

## **The role and jurisdiction of the Ministry of Labour was a source of confusion and delay during the first day of the rescue**

The MOL engineer and inspectors would not arrive at the scene of the collapse until approximately 12:45 a.m. on June 24. Even before their arrival there was confusion and a slight delay related to whether the MOL had somehow shut down the rescue, and whether it was even within its jurisdiction to do so.

### **6:30 p.m.: A decision is likely made by the Community Control Group not to proceed without Ministry of Labour clearance**

At 6:30 p.m., the CCG met in Elliot Lake. This meeting corresponded with the approximate time that Ms. Dennis ordered Mr. Jeffreys to go to Elliot Lake to provide assistance. At the meeting, it appears that a decision was made not to resume the rescue without the clearance of either the Ministry of Labour or an engineer, or both. Somehow, this decision developed into a rumour at the rescue scene that the Ministry of Labour had indeed shut down the rescue.

Notes from the CCG meeting include the first mention anywhere that the MOL might somehow have a say in the resumption of the rescue effort. One set of notes stated: “[C]an’t go in w/o clearance from Min of Labour.”<sup>343</sup> Another set of notes contains the following: “Ministry of Labour – no-one can go in until structural engineer gives go ahead.”<sup>344</sup> A third set of notes stated: “Need MOL clearance based on structural engineer ...”<sup>345</sup> The reference to the MOL is in all cases attributed to the OPP.<sup>346</sup>

Mr. Thorpe (from the Office of the Fire Marshal) also attended the meeting at 6:30 p.m. At 7:36 p.m., he wrote to Ms. Chambers. His email does not specifically mention the MOL but does say that rescue workers were waiting for an engineering opinion before re-entry: “CCG meeting concluded all operations suspended pending arrival of HUSAR team and structural engineer to determine structural integrity.”<sup>347</sup>

The notes from the meeting suggest that MOL clearance and the opinion of an engineer would be required before re-entry. Mr. Thorpe’s email suggests that Chief Officer and others were merely awaiting the opinion of an engineer, not necessarily one from the MOL.

Capt. Thomas of the Elliot Lake Fire Department provided evidence which illustrated the confusion that first day about the role of the MOL. He was not at the CCG meeting, but he had heard about a decision to await MOL clearance. He told the Commission that he thought the order that nobody should enter the building until the MOL had given its approval came from the local incident command, and not from the ministry itself. However, his evidence also suggests that he thought the MOL might have issued it.<sup>348</sup> When pressed about

how he personally learned that ministry approval was required, he was unable to assist the Commission. He described the first hours as a time of confusion and uncertainty:

- Q. Do you recall who, in terms of this communication of the MOL, this stoppage that is noted here, do you know who told you this, because you said you were at the station?
- A. I think, you know, what went on within the first 24 or 36 hours is like a dream. You know, you kind of think you remember something but you are really not quite sure, okay, did that actually happen or did I subconsciously thought it happened? I don't know.
- Like I said, you would have to go through my radio communications. *If I was there, Incident Commander, it would have been radioed to dispatch saying Ministry of Labour has shut us down, or if I was receiving command, it would have been on the radio communication that I had received command from whoever, either Capt. Connors, Captain George, Fire Chief Paul Officer or Ken Barnes. But to sit here without having to look at that, I can't honestly say.*<sup>349</sup> [Emphasis added.]

I cannot determine with certainty whether Chief Officer, the OPP, and others felt they could not re-enter the collapse scene without approval from the MOL and/or an engineer, or whether a decision had simply been made not to do so until the ministry engineer, or an engineer in general, had assessed the situation. Whatever the case may be, the impression developed over the next few hours among some people at the scene and in the media that the MOL had shut down the rescue scene. It was not true – no such order had been issued.

Mr. Jones, for example, said that when he arrived in Elliot Lake at approximately 10:30 p.m., someone told him people were saying the MOL had shut down the operation. He asked who had said that, and no one seemed to know.<sup>350</sup> In truth, Mr. Jones was not even aware that the scene had been evacuated before his arrival. He made it clear to this person that the MOL would not be shutting down the rescue or limiting it under any circumstances:

I can't speak to what happened there before I got there. I was just kind of surprised that when I got there, there was already this talk of the Ministry of Labour shutting down an operation, and I was very surprised. And then they told me that they had cleared it up. It was some kind of miscommunication or misunderstanding between somebody somewhere, and I never was able to find out who, but certainly the Ministry of Labour did not shut down anything.<sup>351</sup>

When Sgt. Gillespie from the UCRT arrived on scene around 11:30 p.m. on June 23, he too heard a rumour that the MOL had shut down the site. However, he was told almost as quickly by Elliot Lake firefighters that it was not true.<sup>352</sup>

The rumour somehow spread to the media and then on to Staff Insp. Neadles and HUSAR/TF3. It created significant confusion for Staff Insp. Neadles and Ms. Chambers. Indeed, it appears to have created additional confusion for Chief Officer, who was working with UCRT on a plan possibly to re-enter the scene.

Shortly after midnight, Staff Insp. Neadles, still en route to Elliot Lake with the HUSAR/TF3 team, wrote to Ms. Chambers about media reports that the MOL had shut the scene down. He expressed frustration and confusion about whether the MOL actually had the jurisdiction to do so and thought he might have to deal with an MOL order shutting down the rescue scene when he arrived in Elliot Lake:

Little bit of a shitfest I see when we get there with the MofL. Media stating NO rescue till they say so ... Where does that come from ... Do they trump us? I have an engineer here??<sup>353</sup>

Staff Insp. Neadles's understanding at the time was that the MOL would not exercise authority over a scene if it was an ongoing rescue, whereas it might do so to some degree during a recovery. He was obviously not certain whether the MOL could use its powers at a rescue scene. He didn't think so but needed clarification.<sup>354</sup>

Ms. Chambers felt from experience that the MOL did not have jurisdiction at an emergency scene, but she also needed to clarify.<sup>355</sup>

At 12:06 a.m., Ms. Chambers wrote to the OFM's Mr. Howse, who was at the scene: "I am advised that the MOL is not allowing the rescue to proceed until they say so. Please find out what is happening there, by liaising with the IC asap. Thanks."<sup>356</sup> Her email seeking clarification instead created more confusion. Mr. Howse appears to have understood from Ms. Chambers's email that the MOL had actually shut the rescue scene down. At 12:13 a.m., he wrote back to Ms. Chambers to say that he was with Chief Officer and that they had discussed the situation. The following emails were exchanged between Ms. Chambers and Mr. Howse:

[Mr. Howse at 12:13 a.m.] With the Chief now and discussing it with OPP they feel its still rescue and have a safe way to continue. They are lowering cameras and monitors down only at this time.

[Ms. Chambers at 12:16 a.m.] Is the MOL there with you? Who is it and who do they report to. Will need to find out. Thx

[Mr. Howse at 12:18 a.m.] They are not here that was the first we heard of it

[Ms. Chambers at 12:39 a.m.] Spoke again with Bill Neadles, who seems to have the only source on this rumour about the MOL stepping up and potentially halting the operation, that being a media report. As discussed, if MOL steps in while the rescue is still ongoing, please notify me immediately so that I can engage the next level in the chain of command to address the blockage asap. Thanks, be safe.

[Ms. Chambers at 12:41 a.m.] PS – this is the Fire Chief's scene and he calls when it's rescue and when it's recovery, as the IC. Thx<sup>357</sup>

Chief Officer's notes and Capt. Thomas's transcription of his radio transmissions both refer to the MOL as having shut down the site at 12:13 a.m. on June 24 – at exactly the same time that Ms. Chambers wrote to Mr. Howse to inquire about the media information. Chief Officer's notes state: "Command advises base that OFM received an email advising that the MOL is shutting us down on the rescue component until the MOL Engineer can do an assessment. UCRT will be sending down camera and equipment but no personnel into the collapse zone."<sup>358</sup> Capt. Thomas's transcription of his radio communications states: "00:13:51 – Received report from Chief – MOL shut down site."<sup>359</sup>

A simple attempt to confirm a media report was, at least for a time, taken as the gospel truth at the rescue scene. Chief Officer agreed that the email traffic created confusion. Indeed, at the time of his testimony, Chief Officer, like Capt. Thomas, still seemed to think the MOL had shut down the rescue at some point:

Q. So it sounds like the original plan was for the UCRT team to have two men ... be lowered into the collapse zone with some form of monitoring equipment, and as a result of this information that the Ministry of Labour was shutting them down, the plan was altered and, rather than people and equipment going into the collapse zone, it was simply now going to be equipment; is that correct?

A. That's right. Yeah, that's right.

...

A. Well, essentially, it was a bit of confusion more so than anything I think on the e-mail and how it all came about. The end result was that there really was, at that stage there was no need to put the officers rappelling into the hole when they could do essentially the same thing by lowering the equipment down.

Q. But was it not more fundamental than that, that it was a question of whether the Ministry of Labour had the power to do it or they didn't have the power to do it?



- A. Well ... that got sorted out as well. You have to remember, that came in from the MOL. It took a little bit of discussion to get that cleared up. I believe that was probably somewhat sorted out as well on chain – you have to remember, MOL, they think they are going to be thinking differently. They are still thinking as under the industrial regulations where this is a rescue. And we had that one hiccup I believe at the start, and that was pretty much it until later.<sup>360</sup>

The confusion lasted for approximately one-half hour. Chief Officer thought it might have been clarified by the email Ms. Chambers sent at 12:39 a.m., saying that the only source of the rumour was a media report.<sup>361</sup> His notes at 12:41 a.m. on June 24 indicate that he advised base that rescue efforts would continue.<sup>362</sup> Capt. Thomas's transcription of his radio communications states: "00:41:00 – Rescue is back on – no paper work from the Ministry of Labour."<sup>363</sup>

### **12:45 a.m.: The Ministry of Labour arrives at the site and rescue efforts continue – confusion about the ministry's role remains**

Ministry of Labour staff arrived at the actual collapse site at approximately 12:45 a.m.<sup>364</sup> Although it was likely already clear to Chief Officer that the MOL had not shut down the site at that point,<sup>365</sup> confusion about the MOL role persisted. As I mentioned earlier, Chief Officer and Capt. Thomas showed confusion about this point during testimony and still appeared to believe that the MOL had shut down the rescue for a time late on June 23.

Ms. Chambers appears also to have continued to believe that the MOL had shut down the site. At 12:58 p.m., she learned from Mr. Howse that the MOL was on scene and had no issues with proceeding. The following exchange, which occurred a little after 1:00 a.m. on June 24, suggests that Ms. Chambers was left with the impression that the MOL had actually attempted to assert jurisdiction and stop or pause the rescue, and might attempt to do so again:

[Mr. Howse at 12:58 a.m.] MOL has arrived on scene they are speaking with the Chief now and at this point have no issues with proceeding, they will be looking at the operations up top accompanied by UCRT members.

...

[Ms. Chambers at 1:01 a.m.] Thank goodness. It really doesn't matter what they think at this RESCUE stage. And monitor to make sure they aren't pushing the FC toward a turnover to RECOVERY until he is comfortable doing so. That would be after OPP UCRT and HUSAR weigh in, I would expect.<sup>366</sup>

I find the apparent confusion about the role of the Ministry of Labour troubling, to say the least. I cannot conclude with certainty how the impression developed that the ministry had shut down the rescue scene, nor can I say with certainty who held the belief and for how long. It is clear that the ministry had not issued any such order, nor even conveyed that it would. The source of the problem appears to flow from a lack of understanding about the scope of MOL powers at ongoing recovery and rescue operations. MOL staff sent to the Mall collapse were uncertain and lacked guidance about their role. People involved with the rescue operation, even experienced ones such as Ms. Chambers, were even more confused. This situation is certain to arise again. When it does, all involved, from MOL staff to boots on the ground, must have a solid understanding of the jurisdiction and role of the MOL at recovery and rescue operations. In this particular case at the Algo Mall, Chief Officer had other reasons to delay the rescue efforts – he needed to wait for expert assistance before resuming. The delay caused by confusion about the role of the MOL appears to have been minimal and of little to no consequence. In future rescues, however, the delay could prove fatal.

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## Deployment of HUSAR/TF3

HUSAR/TF3 was one of two search and rescue teams that deployed in response to the Mall collapse. In this section, I describe the actions of HUSAR/TF3 in its initial eight hours of deployment on June 23 from the perspective of the team members who testified before me, beginning with the notification of the collapse and continuing until the team was on the road to Elliot Lake.

### HUSAR/TF3 personnel who provided accounts of the deployment

#### Staff Insp. William Neadles

Staff Insp. Neadles was the site commander for HUSAR/TF3 – a position that meant he was in charge of the entire team. He has been a member of the Toronto Police Service since 1976. He was a unit commander of the Public Safety and Emergency Management Unit and oversaw the Incident Management Team Program. This role involved, among other things, supervising the Toronto Police Service's response to large-scale events and major planned events. Unplanned events which, because of their size and scope, may have an impact on the entire Toronto Police Service are considered large-scale events, while the Gay Pride and Caribana parades are examples of major planned events.<sup>367</sup>

In addition, Staff Insp. Neadles oversaw the emergency management procedures for the force – in other words, he oversaw all the emergency planning that requires collaboration with other emergency responders, notably fire and Emergency Medical Services (EMS), as well as the City of Toronto's Office of Emergency Management and the emergency management teams of the other city agencies, boards, and commissions.<sup>368</sup>

Staff Insp. Neadles has been involved with HUSAR/TF3 since its inception. In the early days, he was in charge of the search component as a staff sergeant in the Public Order Unit. At the same time, the Province of Ontario was introducing adequacy standards for policing, which made missing persons searches a police responsibility. As the composition of the team took shape, it made sense for the police to take on the search function within the team.<sup>369</sup>

From 2003 on, Staff Insp. Neadles gradually completed his HUSAR/TF3 training. He received structural collapse training at TEEX as well as in Vancouver.<sup>370</sup> His first team position was as a search specialist and then as a search manager. In 2006, he became a site commander,<sup>371</sup> and in 2012, he was one of four site commanders.<sup>372</sup>

In addition to his position on HUSAR/TF3, Staff Insp. Neadles oversees the HUSAR/TF3 program for the Toronto Police Service. All police personnel wishing to join the team have to be approved by him. In order to be considered for approval, a candidate must hold a minimum rank of sergeant and have completed the training prerequisites: a two-week Toronto Police Search and Rescue course as well as a one-week OPP search manager course.<sup>373</sup>

Staff Insp. Neadles is a member of the Toronto HUSAR/TF3 Working Group – the administrative or oversight body that looks after and directs the organization administratively and strategically. Other members of the working group included Capt. Comella from the Fire Department, Cmdr. Michael McCallion from EMS, and Don Sorel from Toronto Water.<sup>374</sup>

Staff Insp. Neadles was appointed to the steering and working committees that developed the Incident Management Service (IMS) doctrine.<sup>375</sup> Consequently, he is very well acquainted with this system.<sup>376</sup>

### **Capt. Tony Comella**

Capt. Comella, the team coordinator of HUSAR/TF3, has been a member of the team since its inception in 1999.<sup>377</sup> He has been a firefighter since 1987. Before assuming his full-time responsibilities with HUSAR/TF3, he was part of the heavy rescue squad with the North York and then the Toronto Fire Services. This squad was responsible for technical rescues, which were mainly auto-extrications.<sup>378</sup>

Beginning in 1988, Capt. Comella had extensive technical rescue training as a firefighter.<sup>379</sup> In early 2000, he became an instructor for the fire service in rope rescue skills. Over the next three years, he renewed his technical skills and then took structural collapse training<sup>380</sup> in California.<sup>381</sup> He is the lead instructor for HUSAR/TF3.<sup>382</sup>

On the Elliot Lake deployment, Capt. Comella said he was, from time to time, the safety officer, operations section chief, and the planning section chief.<sup>383</sup> As operations chief, he would do a scene survey, assess the building's situation, and then propose an incident action plan for the next operational period to the site commander. If the site commander approved the plan, the commander would then assign tasks to the rescue squad.<sup>384</sup>

Capt. Comella appeared to see the role of operations section chief as advisory only, despite the fact that, according to the HUSAR/TF3 organizational chart, the search, rescue, and medical components all report to the operations section chief.<sup>385</sup> He testified that he does not give orders. The squad leaders get their orders from the command post.<sup>386</sup>

### **Cmdr. Michael McCallion**

Cmdr. McCallion was a commander of operations with the Toronto EMS. He joined EMS in 1983,<sup>387</sup> and in 2004 or 2005 he joined HUSAR/TF3 as a medic,<sup>388</sup> going on to become medical manager.<sup>389</sup> He completed Rescue Systems 1 and 2 training in California and Vancouver, and he has acted as an instructor for HUSAR/TF3.<sup>390</sup>

When Cmdr. McCallion left for Elliot Lake, it was his expectation that he would be the medical manager. It was only after he arrived in Elliot Lake that his role changed, and he became a site commander<sup>391</sup> for the first time.<sup>392</sup>

### **Capt. Martin McRae**

Capt. McRae is a captain with the Toronto Fire Service, where he teaches firefighters who are assigned to the heavy rescue trucks. The courses he covers include confined space and high-angled rescue.<sup>393</sup> He joined HUSAR/TF3 in 2003 as an instructor.<sup>394</sup> On deployments he is usually a rescue specialist.<sup>395</sup> However, on this deployment, Capt. McRae was occupied primarily as the logistics section chief,<sup>396</sup> because that post was vacant.<sup>397</sup>

### **Capt. Chuck Guy**

Capt. Guy is a 34-year veteran of the Toronto Fire Service. He was one of the original members of HUSAR/TF3. He has acted as an instructor since that time, teaching each of the five core courses described earlier. He has been a technical rescue instructor with Toronto Fire Service for 15 years.<sup>398</sup> On the Elliot Lake deployment, he was a rescue squad leader.<sup>399</sup>

### **Don Sorel**

Mr. Sorel is the manager in charge of the operation, maintenance, and inspection of the combined sanitary and storm trunk sewer within the City of Toronto. He has worked for the city for 35 years. He is knowledgeable and experienced in the operation of heavy equipment and joined HUSAR/TF3 in 2003. He completed Rescue Systems 1 in Vancouver and Rescue Systems 2 in California in 2004. In addition to the rigging training offered in Rescue Systems 2, he has rigging experience through his regular employment.<sup>400</sup>



### **Sgt. Scott Fowlds**

Sgt. Fowlds is a sergeant with the Toronto Police Service canine unit. He joined the Toronto Police Service in 1990 and the canine unit in 1994, where he remained until 2007. He returned to the unit in 2009 as a supervisor.<sup>401</sup> He deployed to Elliot Lake with his dog Ranger.<sup>402</sup> He has also received the same structural collapse training as the other team members.<sup>403</sup>

### **Sgt. Phil Glavin**

Sgt. Glavin is a 34-year veteran of the Toronto Police Service who holds the rank of sergeant. He is part of the in-service training team at the Toronto Police College. In addition, he is also a search manager.<sup>404</sup> Sgt. Glavin joined HUSAR/TF3 in 2007. His role is a technical search specialist, and he uses equipment, as opposed to dogs, to assist in the search.<sup>405</sup>

### **James Cranford**

Mr. Cranford is a structural engineer who has worked for Stephenson Engineering since 2008. He first became involved with HUSAR/TF3 in 2010. At that time, he volunteered to attend a training exercise with the team, but did not receive any search and rescue training. However, he did accompany the unit to the Goderich deployment in 2011.<sup>406</sup>

Mr. Cranford understood his role as an engineer to be advisory. If team members had questions about the structure, how it was constructed or how it reacted to the collapse, they could seek his opinion. This advice could include methods of shoring. He did not see his role as including an assessment of whether the building was safe.<sup>407</sup>

### **Dr. Michael Feldman**

Dr. Feldman deployed to Elliot Lake as a physician. He specializes in emergency medicine and has practised that specialty at Sunnybrook Health Sciences Centre since 2005. He is also the medical director for the Toronto Fire Service. Sunnybrook Hospital in Toronto provides physicians to HUSAR/TF3 pursuant to a memorandum of understanding.

Dr. Feldman has worked with HUSAR/TF3 since 2006<sup>408</sup> and has trained in structural collapse rescue. In addition to this training, he has participated in exercises with HUSAR/TF3, as well as taken a disaster medical specialist course.<sup>409</sup>

## **Cost of the HUSAR/TF3 deployment is paid for by the province**

When HUSAR/TF3 is deployed as a provincial asset, the memorandum of understanding between the City of Toronto and the Province of Ontario provides that the province assumes the cost of the salaries and expenses associated with the deployment. Staff Insp. Neadles testified that if he was going to incur significant single expenses exceeding \$10,000, he would need to seek the approval of the Office of the Fire Marshal, through Ms. Chambers.<sup>410</sup>

## **3:45 p.m.: HUSAR/TF3 is notified of possible deployment**

Staff Insp. Neadles was the on-call site commander for the month of June 2012.<sup>411</sup> According to his notes, at approximately 3:45 p.m. on June 23, he was told of the Mall collapse by Toronto Fire Services communications. He was also told that the Office of the Fire Marshal was anticipating the deployment of HUSAR/TF3 and inquiring

the time it would take to deploy. Ms. Chambers was identified as his contact at the Office of the Fire Marshal.<sup>412</sup> This call was characterized as a “heads up”: the normal approval process must take place before any deployment can happen. Once the approval is given, the call-out for the team members can begin.<sup>413</sup>

As soon as Staff Insp. Neadles received this information, according to his notes, he called and left a message for Capt. Comella. He then contacted Ms. Chambers at 4 p.m. She told him that UCRT was already en route and asked him how long it would take to deploy the team.<sup>414</sup> At 4:21 p.m., Staff Insp. Neadles received approval from Deputy Fire Chief Ronald Jenkins to deploy the team.<sup>415</sup> The call-out could commence.

Capt. Comella received a heads-up that HUSAR/TF3 might be deployed for the Mall collapse at 3:30 p.m., even earlier than Staff Insp. Neadles, when Division Chief Doug Silver of the Toronto Fire Service called him. At 3:35 p.m., Capt. Comella, in turn, put Capt. McRae on notice of the possible deployment.<sup>416</sup> At the time, Capt. McRae was participating in a HUSAR/TF3 training exercise at Rouge Valley, a natural environment park in the east end of the Greater Toronto Area.<sup>417</sup>

### **Approximately 4 p.m.: HUSAR/TF3 is deployed**

Capt. Comella received confirmation of the deployment from Division Chief Silver at 4:05 p.m.<sup>418</sup> Capt. McRae said he was notified by Capt. Comella shortly before 4 p.m. that the team was being deployed. He later corrected himself, saying it was Staff Insp. Neadles who made the call. That, however, does not appear likely because it was not until 4:21 p.m. that Staff Insp. Neadles received approval of the deployment from Deputy Chief Jenkins. In any event, at 4 p.m., according to his notes, Capt. McRae instructed those HUSAR/TF3 members who were on training to return to the staging areas.<sup>419</sup>

### **The call-out gets barely half a full team**

The technical elements of the call-out procedure for HUSAR/TF3 were described earlier. The Elliot Lake experience demonstrates a glaring and worrisome feature of the procedure – the lack of predictability of the response to the call-out. The team leaders do not know in advance who will be showing up. As I describe later in this Report, this deployment suffered from a low turnout as well as an absence of key personnel, most notably a trained planning section chief.

Based on the organizational chart<sup>420</sup> prepared by Capt. Comella and the deployment roster disclosed to the Inquiry, it appears that 33 team members and three drivers were deployed by HUSAR/TF3 on June 23.<sup>421</sup> The fact that it was a training day was a plus, according to Staff Insp. Neadles. It meant that a number of the instructors who were participating in the training would be available for deployment – an enhanced and experienced leadership presence.<sup>422</sup>

The limited turnout – less than half of the potential complement – is illustrative of a major weakness of the HUSAR/TF3 call-out system. Because the team is made up of volunteers, the members cannot be forced to attend, despite a commitment to do so. Luck is therefore a major determinant of availability.

### **4 p.m. to 10 p.m.: between the call-out and wheels-up**

As mentioned earlier, at 4 p.m., Capt. McRae started the process of rounding up the members who had been training at Rouge Valley and were scattered through this forested area.<sup>423</sup> Once they were back at the staging area, and everyone had been accounted for, they all travelled back to the HUSAR/TF3 building – which is also known as the home of operations. A number of instructors, including Capt. McRae, travelled in a support vehicle,

while the rest of the members returned to the building by bus. Not everyone who had been training was available for deployment. The bus dropped all the members off at the home of operations so they could pick up their cars, and those who were going to deploy went home to get needed personal items.<sup>424</sup>

The bus left Rouge Valley at 4:50 p.m. and arrived at HUSAR/TF3's home of operations at 5:35 p.m. Capt. McRae and his colleagues had arrived there at 5:10 p.m.<sup>425</sup> Immediately, Capt. McRae and others began work on the necessary tasks to allow the vehicles and the equipment to travel to Elliot Lake.

### 5:05 p.m.: HUSAR/TF3 has problems obtaining tractors and drivers

HUSAR/TF3 owns the trailers that transport its equipment; however, it does not own any tractors to pull them and must rely on rental tractors. At 5:05 p.m., Capt. McRae called Paul Demy, HUSAR/TF3's main driver, and instructed him to arrange for the rental of the tractors and to line up the drivers for them. Capt. McRae acknowledged that he would have known from the time he found out that they were going to be deployed (4 p.m.) that these arrangements would have to be made. The delay of over one hour in calling Mr. Demy, he explained, arose because his first priority was to get the training group back safely to the staging area.<sup>426</sup>

Mr. Demy had trouble finding both drivers and tractors, so Capt. McRae phoned Mr. Sorel at 5:12 p.m. for assistance. Ultimately, it was Mr. Sorel who got the drivers.<sup>427</sup> Mr. Sorel testified that he was called because Toronto Water had supplied drivers in the past when there was no other alternative. He explained that his heavy equipment operators have the AZ licences required to operate a tractor-trailer combination.<sup>428</sup> However, there is no formal arrangement between HUSAR/TF3 and Toronto Water to supply drivers. On this occasion, Mr. Sorel assisted in getting the drivers because he realized that the team would be unable to leave without them.<sup>429</sup>

Mr. Sorel received approval from his general manager at Toronto Water to deploy three drivers. He contacted their supervisor for assistance in contacting them, and, between the two of them, they managed to get three drivers.<sup>430</sup>

After being contacted, the drivers reported to the home of operations, located on Old Eglinton Avenue near the Don Valley Parkway. It is also the site where HUSAR/TF3 team members do some of their training and store their deployment equipment,<sup>431</sup> including their kit bags.<sup>432</sup> At 6:08 p.m., the truck drivers left the home of operations in a police vehicle to pick up the tractors that had been located in Mississauga, approximately 25 kilometres away.<sup>433</sup> They arrived back at 8:10 p.m.<sup>434</sup>

On January 1, 2013, Mr. Sorel resigned from HUSAR/TF3 and its steering committee because of his work commitments. He informed the Inquiry that one of the drivers was injured in Elliot Lake, and this injury had adverse consequences for his unit. Consequently, HUSAR/TF3 will not be able to call on Toronto Water's drivers in the future. He informed the steering committee of that fact so it could make alternative arrangements. He was not aware of what steps, if any, have been taken to remedy this situation. I, too, have not been informed of any arrangements.<sup>435</sup>

### The muster point

The HUSAR/TF3 members who are deploying report to a muster point. For the Elliot Lake deployment, the muster point was the Public Order Unit facility of the Toronto Police Service, located near the intersection of McCowan Road and Finch Avenue in Toronto.<sup>436</sup>



At the muster point, the members received a brief physical examination from either a doctor or a paramedic to ensure that they were healthy enough to work on the pile.<sup>437</sup> They were then given their kit bags,<sup>438</sup> containing their uniforms, personal protective equipment, helmet, and other items.<sup>439</sup> They also received a briefing from the site commander.<sup>440</sup>

Although it may appear inefficient to have the members report for duty at a place different from where their equipment is stored, the muster point is a more suitable venue as a staging area for the members than the home of operations. It has an auditorium, secure parking facilities, and sufficient space to accommodate the physical examinations and to allow the members to change into their team gear. The home of operations, in contrast, is more like a warehouse.<sup>441</sup>

### **8:05 p.m.: Vans and equipment depart the home of operations for muster point**

At 5:20 p.m., Capt. McRae instructed members to fuel the vehicles and get the trailers ready. At the same time, he ordered a member to get the kit bags loaded into a cube van so they could be transported to the muster point. Because the team management does not know who is going to show up for deployment, they pack all 100 or so member bags into the van. The cube van was loaded at 7:57 p.m., more than 2.5 hours later. Capt. McRae testified that the task could reasonably be done in less than an hour.<sup>442</sup> I heard no evidence justifying the delay.

The deployment equipment, other than the members' kits, is stored on the trailers and is ready to go. Depending on the needs of the particular deployment, not all the equipment will be taken. In this case, only three of the four trailers were needed, requiring a rearranging of the loads.<sup>443</sup>

The loaded cube vans left the home of operations at 8:05 p.m. and arrived at the muster point at 8:28 p.m. The members were issued their kits by 9:15 p.m.<sup>444</sup> According to Staff Insp. Neadles's notes, the team bus left the muster point at 9:30 p.m. to rendezvous with the vehicles, which would be leaving from the home of operations.<sup>445</sup>

### **9:56 p.m.: Drivers and tractors leave home of operations**

Meanwhile, at 8:10 p.m., the drivers and the tractors arrived back at the home of operations after picking up the tractors in Mississauga. All vehicles left that location at approximately 9:56 p.m. to meet up with the team bus at a Petro Canada station north of Toronto,<sup>446</sup> in order to travel to Elliot Lake in a convoy. The team bus carried most team members, including Staff Insp. Neadles, Cmdr. McCallion, and Mr. Cranford. Other members such as Capt. Comella, Capt. McRae,<sup>447</sup> and Sgt. Fowlds<sup>448</sup> went up in other vehicles, but in the convoy.

Mr. Sorel was able to deploy the next day and made his way to Elliot Lake on his own.<sup>449</sup> Dr. Feldman was on shift when he was notified of the deployment shortly before 5 p.m. He arranged for another doctor to deploy first. He went to Elliot Lake the next morning, arriving there in the early afternoon.<sup>450</sup>

### **It takes almost six hours for HUSAR/TF3 to get out the door**

Capt. McRae indicated that HUSAR/TF3 is mandated by the national program to respond – to get out the door – in six hours.<sup>451</sup> Capt. Comella similarly said the team has to be on the road, heading to the call, within six hours.<sup>452</sup> I recognize that mobilizing this type of operation may present challenges. However, I was struck by how long it took to get on the road to Elliot Lake. I discuss this matter further in the analysis chapter of the Report.

## Staff Insp. Neadles's actions

At 5:31 p.m., Ms. Chambers informed Staff Insp. Neadles by email that the "FC says a 30 x 60 area involved. Lots of concrete. 1 person suspected viable but not accessible. 2nd potential."<sup>453</sup> At 6:27 p.m., she sent him a further email that the responders were evacuating the building because of its unsafe condition. She also confirmed that there was one death (VSA).<sup>454</sup>

At 5:25 p.m., Ms. Chambers had asked Staff Insp. Neadles to inform her when he knew the size of his team and the time they would be leaving.<sup>455</sup> At 7:28 p.m., he replied that they had about 34 members, but did not provide a time of departure.<sup>456</sup> She suggested that, because of the situation, it would be preferable for the team to leave then with what they had rather than waiting to get 65 or 70 members, which could have caused further delay. She once again asked about a departure time.<sup>457</sup> He replied that they were "shooting for 20:30 hours."<sup>458</sup> Staff Insp. Neadles agreed that waiting would likely have made no difference. They would not likely have got more than 34 responders, given that the call-out had been made over three hours earlier.\*

At 8:23 p.m., Staff Insp. Neadles informed Ms. Chambers that the departure would be held up by at least 30 to 60 minutes owing to a tractor delay.<sup>459</sup> Even if the team had not encountered problems in getting the rental tractors, it would not have been ready to leave at 8:30 p.m. because the kits were being issued to the team members until 9:15 p.m.

On the bus trip to Elliot Lake, Staff Insp. Neadles showed Mr. Cranford some photographs taken of the collapse site. He testified that he did not find the photos very useful: all they showed him was that the collapse was in a sealed building with a pre-cast concrete slab system. He and a team member had googled the Mall website, where they found a basic layout. That is the extent of the information he possessed en route.<sup>460</sup> For his part, Staff Insp. Neadles did not recall seeing any photographs of the collapse zone.<sup>461</sup> However, the email traffic indicates that photos were sent to him at 7:57 p.m.<sup>462</sup> and the plans at 12:02 a.m.<sup>463</sup>

At about 9:24 p.m., Staff Insp. Neadles spoke to Chief Officer by telephone. Chief Officer provided him with information, including that there were two fatalities, that the total number of victims was unknown, and that one female victim, still alive, had been spoken to.<sup>464</sup>

As discussed earlier, Staff Insp. Neadles sent an email to Ms. Chambers shortly after midnight on June 24, telling her that the media were reporting that there would be no rescue until the Ministry of Labour allowed the rescue to proceed. There does not appear to be any factual foundation for the speculation that the ministry had halted any rescue operation. What the incident revealed, however, was confusion among experienced emergency personnel about the ministry's power to enforce the *Occupational Health and Safety Act* at the scene of an emergency rescue. I return to this issue later in my Report.

The team arrived in Elliot Lake at 4:18 a.m.

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\* Neadles testimony, September 10, 2013, p. 25260. Staff Insp. Neadles refers to 34 responders. The actual deployment roster lists 33.

## Notes

- <sup>1</sup> The videos and a re-creation by NORR can be found at Exhibits 7796 and 3141.
- <sup>2</sup> Exhibit 6258.
- <sup>3</sup> Morrissey testimony, August 7, 2013, pp. 19845–7; Exhibit 7796.
- <sup>4</sup> Morrissey testimony, August 7, 2013, pp. 19848–9; Exhibit 7924, p. 055.
- <sup>5</sup> Morrissey testimony, August 7, 2013, pp. 19849–55.
- <sup>6</sup> Morrissey testimony, August 7, 2013, pp. 19852–4.
- <sup>7</sup> Morrissey testimony, August 7, 2013, pp. 19856–7.
- <sup>8</sup> Morrissey testimony, August 7, 2013, pp. 19857–8.
- <sup>9</sup> Marceau testimony, August 7, 2013, p. 19811.
- <sup>10</sup> Marceau testimony, August 7, 2013, p. 19798.
- <sup>11</sup> Marceau testimony, August 7, 2013, pp. 19790–5.
- <sup>12</sup> Marceau testimony, August 7, 2013, pp. 19794–7.
- <sup>13</sup> Marceau testimony, August 7, 2013, pp. 19800–1.
- <sup>14</sup> Marceau testimony, August 7, 2013, pp. 19801–4.
- <sup>15</sup> Marceau testimony, August 7, 2013, pp. 19805–9.
- <sup>16</sup> Bérubé testimony, August 7, 2013, pp. 19814–15.
- <sup>17</sup> Bérubé testimony, August 7, 2013, p. 19830; Exhibit 7924, p. 034.
- <sup>18</sup> Bérubé testimony, August 7, 2013, pp. 19817–19.
- <sup>19</sup> Bérubé testimony, August 7, 2013, pp. 19819–20.
- <sup>20</sup> Bérubé testimony, August 7, 2013, p. 19820.
- <sup>21</sup> Bérubé testimony, August 7, 2013, pp. 19820–1, and 19823.
- <sup>22</sup> Bérubé testimony, August 7, 2013, p. 19822.
- <sup>23</sup> Bérubé testimony, August 7, 2013, pp. 19825–7.
- <sup>24</sup> Bérubé testimony, August 7, 2013, pp. 19829–30.
- <sup>25</sup> Bérubé testimony, August 7, 2013, p. 19828.
- <sup>26</sup> Bérubé testimony, August 7, 2013, p. 19828.
- <sup>27</sup> Bérubé testimony, August 7, 2013, p. 19832–4.
- <sup>28</sup> Amyotte testimony, August 7, 2013, pp. 19769–71.
- <sup>29</sup> Amyotte testimony, August 7, 2013, p. 19773.
- <sup>30</sup> Amyotte testimony, August 7, 2013, pp. 19774–5.
- <sup>31</sup> Amyotte testimony, August 7, 2013, pp. 19776–8.
- <sup>32</sup> Amyotte testimony, August 7, 2013, pp. 19778–80.
- <sup>33</sup> Perizzolo and Latulippe testimony, August 7, 2013, pp. 19865–6.
- <sup>34</sup> Perizzolo and Latulippe testimony, August 7, 2013, pp. 19866–7.
- <sup>35</sup> Perizzolo and Latulippe testimony, August 7, 2013, pp. 19868–72.
- <sup>36</sup> Perizzolo and Latulippe testimony, August 7, 2013, p. 19873.
- <sup>37</sup> Mr. and Mrs. Aylwin testimony, August 7, 2013, pp. 19963–5.
- <sup>38</sup> Mr. and Mrs. Aylwin testimony, August 7, 2013, p. 19965.
- <sup>39</sup> Mr. and Mrs. Aylwin testimony, August 7, 2013, pp. 19965–6.
- <sup>40</sup> Gendron testimony, August 8, 2013, pp. 20017–18.
- <sup>41</sup> Gendron testimony, August 8, 2013, pp. 20018–19.
- <sup>42</sup> Gendron testimony, August 8, 2013, pp. 20020–3.
- <sup>43</sup> Gendron testimony, August 8, 2013, p. 20023.
- <sup>44</sup> Mr. and Mrs. Aylwin testimony, August 7, 2013, pp. 19966–9.
- <sup>45</sup> Exhibits 7670 and 9916–33.
- <sup>46</sup> Thomas testimony, August 15, 2013, pp. 21017–20.
- <sup>47</sup> Thomas testimony, August 15, 2013, pp. 21021–2.
- <sup>48</sup> Officer testimony, August 21, 2013, p. 21562.
- <sup>49</sup> Exhibit 8025.
- <sup>50</sup> Officer testimony, August 21, 2013, p. 21568.
- <sup>51</sup> Officer testimony, August 21, 2013, pp. 21565–7.
- <sup>52</sup> Exhibit 8025.
- <sup>53</sup> Officer testimony, August 21, 2013, pp. 21571–2; Exhibit 8025.
- <sup>54</sup> Exhibit 8025.
- <sup>55</sup> Thomas testimony, August 15, 2013, pp. 21032–5.
- <sup>56</sup> Thomas testimony, August 15, 2013, pp. 21035–6, and 21040.
- <sup>57</sup> Officer testimony, August 21, 2013, p. 21573.
- <sup>58</sup> Officer testimony, August 21, 2013, pp. 21535–9, and 21543–4; Exhibit 7941.
- <sup>59</sup> Officer testimony, August 21, 2013, pp. 21544–6.
- <sup>60</sup> Officer testimony, August 21, 2013, p. 21569.
- <sup>61</sup> Thomas testimony, August 15, 2013, pp. 21027–8.
- <sup>62</sup> Officer testimony, August 21, 2013, pp. 21570–1.
- <sup>63</sup> Thomas testimony, August 15, 2013, pp. 21022–3.
- <sup>64</sup> Officer testimony, August 21, 2013, pp. 21579–80; Exhibit 8025.
- <sup>65</sup> Exhibit 8025.
- <sup>66</sup> Officer testimony, August 21, 2013, pp. 21573–4.
- <sup>67</sup> Officer testimony, August 21, 2013, pp. 21632–3.
- <sup>68</sup> Officer testimony, August 21, 2013, pp. 21573–4.
- <sup>69</sup> Officer testimony, August 21, 2013, p. 21575.
- <sup>70</sup> Exhibit 8025.
- <sup>71</sup> Exhibit 8025.
- <sup>72</sup> Officer testimony, August 21, 2013, pp. 21605–6.
- <sup>73</sup> Officer testimony, August 21, 2013, pp. 21582–3, and 21608.
- <sup>74</sup> Officer testimony, August 21, 2013, pp. 21580–2; Exhibit 8025.
- <sup>75</sup> Officer testimony, August 21, 2013, pp. 21574–5.
- <sup>76</sup> Officer testimony, August 21, 2013, pp. 21584–5; Exhibit 8025.
- <sup>77</sup> Thomas testimony, August 15, 2013, pp. 21036–8.
- <sup>78</sup> Officer testimony, August 21, 2013, pp. 21584–5.
- <sup>79</sup> Officer testimony, August 21, 2013, pp. 21587–8; Exhibit 7798.
- <sup>80</sup> Officer testimony, August 21, 2013, pp. 21588–90.
- <sup>81</sup> Officer testimony, August 21, 2013, pp. 21590–1.
- <sup>82</sup> Exhibit 8025.
- <sup>83</sup> Officer testimony, August 21, 2013, p. 21610.
- <sup>84</sup> Connors testimony, August 20, 2013, pp. 21374–5.
- <sup>85</sup> Connors testimony, August 20, 2013, p. 21375.
- <sup>86</sup> Connors testimony, August 20, 2013, pp. 21378–81.
- <sup>87</sup> Exhibit 9673.
- <sup>88</sup> Exhibit 3743.
- <sup>89</sup> Hamilton testimony, October 7, 2013, p. 28504.
- <sup>90</sup> deBortoli testimony, October 7, 2013, pp. 28393–6.
- <sup>91</sup> Mantha testimony, September 23, 2013, pp. 26733–7.
- <sup>92</sup> Mantha testimony, September 23, 2013, pp. 26737–9.
- <sup>93</sup> Officer testimony, August 21, 2013, pp. 21597–8; Exhibit 8025.
- <sup>94</sup> Officer testimony, August 21, 2013, p. 21599; Exhibit 8025.
- <sup>95</sup> Exhibit 8025.
- <sup>96</sup> Exhibit 6250.
- <sup>97</sup> Needles testimony, September 10, 2013, pp. 25242–3.
- <sup>98</sup> Hamilton testimony, October 7, 2013, pp. 28504–6; deBortoli testimony, October 7, 2013, p. 28391.
- <sup>99</sup> Exhibit 8114.
- <sup>100</sup> Exhibit 8025.
- <sup>101</sup> Thomas testimony, August 15, 2013, pp. 21041–4.
- <sup>102</sup> Thomas testimony, August 15, 2013, pp. 21045–8.
- <sup>103</sup> Exhibit 7524.
- <sup>104</sup> Connors testimony, August 20, 2013, pp. 21383–5; Exhibit 6296.
- <sup>105</sup> Connors testimony, August 20, 2013, pp. 21385–7.
- <sup>106</sup> Connors testimony, August 20, 2013, pp. 21388–90.
- <sup>107</sup> Officer testimony, August 21, 2013, pp. 21602–3.
- <sup>108</sup> Thomas testimony, August 15, 2013, pp. 21047–9; Connors testimony, August 20, 2013, pp. 21391–2.
- <sup>109</sup> Thomas testimony, August 15, 2013, pp. 21057–60.
- <sup>110</sup> Exhibit 8025.



- <sup>111</sup> Officer testimony, August 21, 2013, pp. 21610–13; Exhibit 8025.
- <sup>112</sup> Thomas testimony, August 15, 2013, p. 21066.
- <sup>113</sup> Exhibit 8025.
- <sup>114</sup> Officer testimony, August 21, 2013, pp. 21613–14.
- <sup>115</sup> Exhibit 3743.
- <sup>116</sup> Officer testimony, August 21, 2013, p. 21631.
- <sup>117</sup> Exhibit 7965; deBortoli testimony, October 7, 2013, pp. 28398–9.
- <sup>118</sup> Thomas testimony, August 15, 2013, pp. 21049–52; Exhibit 6336.
- <sup>119</sup> Thomas testimony, August 15, 2013, pp. 21053–7.
- <sup>120</sup> Connors testimony, August 21, 2013, pp. 21415–18.
- <sup>121</sup> Officer testimony, August 21, 2013, pp. 21614–17.
- <sup>122</sup> Officer testimony, August 21, 2013, pp. 21617–19.
- <sup>123</sup> Officer testimony, August 21, 2013, p. 21621; Exhibit 8025.
- <sup>124</sup> Officer testimony, August 21, 2013, p. 21621.
- <sup>125</sup> Exhibit 7524.
- <sup>126</sup> Connors testimony, August 21, 2013, pp. 21409–11.
- <sup>127</sup> Thomas testimony, August 15, 2013, pp. 21061–4.
- <sup>128</sup> Connors testimony, August 21, 2013, pp. 21419–22; Exhibit 8025.
- <sup>129</sup> Officer testimony, August 21, 2013, pp. 21620–1; Exhibit 8025.
- <sup>130</sup> Exhibit 8025.
- <sup>131</sup> Officer testimony, August 21, 2013, pp. 21592–4.
- <sup>132</sup> Thomas testimony, August 15, 2013, pp. 21064–6.
- <sup>133</sup> Officer testimony, August 21, 2013, pp. 21624–5; Exhibit 8025.
- <sup>134</sup> Exhibit 8025.
- <sup>135</sup> Thomas testimony, August 15, 2013, pp. 21067–70.
- <sup>136</sup> Officer testimony, August 29, 2013, pp. 23354–5.
- <sup>137</sup> Officer testimony, August 29, 2013, pp. 23356–7, and 23364–6.
- <sup>138</sup> Thomas testimony, August 15, 2013, pp. 21072–5.
- <sup>139</sup> Officer testimony, August 21, 2013, pp. 21628–9; Exhibit 8025.
- <sup>140</sup> Exhibit 3743.
- <sup>141</sup> Officer testimony, August 21, 2013, pp. 21657–8; Exhibit 3743.
- <sup>142</sup> Officer testimony, August 21, 2013, p. 21659.
- <sup>143</sup> Exhibits 3743 and 8025.
- <sup>144</sup> Gillespie testimony, September 3, 2013, pp. 23461–4.
- <sup>145</sup> Gillespie testimony, September 3, 2013, pp. 23455–9.
- <sup>146</sup> Gillespie testimony, September 3, 2013, pp. 23464–5.
- <sup>147</sup> Gillespie testimony, September 3, 2013, pp. 23472–5.
- <sup>148</sup> Cox testimony, August 26, 2013, pp. 22202–3.
- <sup>149</sup> Cox testimony, August 26, 2013, pp. 22209–10.
- <sup>150</sup> Cox testimony, August 26, 2013, pp. 22214–15.
- <sup>151</sup> Bailey testimony, August 27, 2013, pp. 22685–6.
- <sup>152</sup> Bailey testimony, August 27, 2013, pp. 22706–7.
- <sup>153</sup> Bailey testimony, August 27, 2013, p. 22710.
- <sup>154</sup> Hulsman testimony, August 28, 2013, pp. 22882–3.
- <sup>155</sup> Hulsman testimony, August 28, 2013, p. 22892.
- <sup>156</sup> Hulsman testimony, August 28, 2013, pp. 22902–3.
- <sup>157</sup> Waddick testimony, August 23, 2013, p. 21949.
- <sup>158</sup> Waddick testimony, August 23, 2013, pp. 21951–3.
- <sup>159</sup> Gillespie testimony, September 3, 2013, pp. 23506–7.
- <sup>160</sup> Gillespie testimony, September 3, 2013, pp. 23504–5.
- <sup>161</sup> Gillespie testimony, September 3, 2013, pp. 23498–9.
- <sup>162</sup> Gillespie testimony, September 3, 2013, p. 23508.
- <sup>163</sup> Gillespie testimony, September 3, 2013, pp. 23512–13.
- <sup>164</sup> Gillespie testimony, September 3, 2013, p. 23512.
- <sup>165</sup> Exhibit 7847.
- <sup>166</sup> Gillespie testimony, September 3, 2013, pp. 23512–13.
- <sup>167</sup> Cox testimony, August 26, 2013, pp. 22252–3.
- <sup>168</sup> Gillespie testimony, September 3, 2013, pp. 23525–6.
- <sup>169</sup> Cox testimony, August 26, 2013, pp. 22253–4.
- <sup>170</sup> Cox testimony, August 26, 2013, pp. 22256–7.
- <sup>171</sup> Cox testimony, August 26, 2013, pp. 22258–9.
- <sup>172</sup> Waddick testimony, August 23, 2013, p. 21976.
- <sup>173</sup> Waddick testimony, August 23, 2013, p. 21976.
- <sup>174</sup> Waddick testimony, August 23, 2013, pp. 21978–9.
- <sup>175</sup> Gillespie testimony, September 3, 2013, pp. 23513–14.
- <sup>176</sup> Gillespie testimony, September 3, 2013, pp. 23518–20.
- <sup>177</sup> Chambers testimony, September 18, 2013, p. 26079.
- <sup>178</sup> Chambers testimony, September 18, 2013, p. 26083.
- <sup>179</sup> Gillespie testimony, September 3, 2013, pp. 23526–7.
- <sup>180</sup> Jollymore testimony, September 23, 2013, pp. 26801–5.
- <sup>181</sup> Jollymore testimony, September 23, 2013, pp. 26811–12.
- <sup>182</sup> Jollymore testimony, September 23, 2013, pp. 26813–15.
- <sup>183</sup> Jollymore testimony, September 23, 2013, pp. 26811–14.
- <sup>184</sup> Jollymore testimony, September 23, 2013, pp. 26817–9.
- <sup>185</sup> Jollymore testimony, September 24, 2013, pp. 26989–90.
- <sup>186</sup> Cox testimony, August 26, 2013, p. 22260.
- <sup>187</sup> Gillespie testimony, September 3, 2013, pp. 23527–30.
- <sup>188</sup> Jollymore testimony, September 24, 2013, pp. 26933–4.
- <sup>189</sup> Jollymore testimony, September 24, 2013, pp. 26955–6.
- <sup>190</sup> Cox testimony, August 26, 2013, pp. 22262–4.
- <sup>191</sup> Cox testimony, August 26, 2013, p. 22265.
- <sup>192</sup> Exhibit 6396, p. 3.
- <sup>193</sup> Jollymore testimony, September 23, 2013, pp. 26844–6.
- <sup>194</sup> Jollymore testimony, September 23, 2013, p. 26851.
- <sup>195</sup> Cox testimony, August 26, 2013, p. 22265.
- <sup>196</sup> Exhibit 6377.
- <sup>197</sup> Cox testimony, August 26, 2013, p. 22265.
- <sup>198</sup> Cox testimony, August 26, 2013, pp. 22265–7.
- <sup>199</sup> Cox testimony, August 26, 2013, pp. 22267–8.
- <sup>200</sup> Gillespie testimony, September 3, 2013, pp. 23527–8.
- <sup>201</sup> Gillespie testimony, September 3, 2013, pp. 23532–3.
- <sup>202</sup> Jollymore testimony, September 23, 2013, pp. 26851–2.
- <sup>203</sup> Jollymore testimony, September 23, 2013, pp. 26852–3.
- <sup>204</sup> Jollymore testimony, September 23, 2013, pp. 26853–5.
- <sup>205</sup> Jollymore testimony, September 23, 2013, pp. 26858–60.
- <sup>206</sup> Jollymore testimony, September 23, 2013, pp. 26861–2.
- <sup>207</sup> Jollymore testimony, September 24, 2013, p. 26986.
- <sup>208</sup> Exhibit 3743, pp. 6–7.
- <sup>209</sup> deBortoli testimony, October 7, 2013, pp. 28418–19.
- <sup>210</sup> Cox testimony, August 26, 2013, pp. 22286–9.
- <sup>211</sup> Jollymore testimony, September 24, 2013, pp. 26875–6.
- <sup>212</sup> Jollymore testimony, September 23, 2013, p. 26866.
- <sup>213</sup> Exhibit 3743, p. 14.
- <sup>214</sup> Jollymore testimony, September 23, 2013, pp. 26866–7.
- <sup>215</sup> deBortoli testimony, October 7, 2013, pp. 28435–6.
- <sup>216</sup> Selvers testimony, September 9, 2013, pp. 24992–6.
- <sup>217</sup> Selvers testimony, September 9, 2013, pp. 24998–9.
- <sup>218</sup> Selvers testimony, September 9, 2013, p. 25001–4.
- <sup>219</sup> Selvers testimony, September 9, 2013, p. 25004.
- <sup>220</sup> Selvers testimony, September 9, 2013, p. 25007.
- <sup>221</sup> Selvers testimony, September 9, 2013, pp. 25009–10.
- <sup>222</sup> Selvers testimony, September 9, 2013, pp. 25012–13.
- <sup>223</sup> Selvers testimony, September 9, 2013, pp. 25016–18.
- <sup>224</sup> Gillespie testimony, September 3, 2013, p. 23533.
- <sup>225</sup> Exhibit 245; Cox testimony, August 26, 2013, pp. 22271–3.
- <sup>226</sup> Cox testimony, August 26, 2013, pp. 22282–6.

- 227 Gillespie testimony, September 3, 2013, pp. 23539–41.
- 228 Burns testimony, August 20, 2013, pp. 21270–1.
- 229 Cox testimony, August 26, 2013, pp. 22291–2.
- 230 Bailey testimony, August 27, 2013, pp. 22722–30.
- 231 Cox testimony, August 26, 2013, pp. 22293–6; Exhibit 2114; Exhibit 2115.
- 232 Cox testimony, August 26, 2013, pp. 22294–7.
- 233 Cox testimony, August 26, 2013, pp. 22297–8.
- 234 Cox testimony, August 26, 2013, pp. 22294–7.
- 235 Cox testimony, August 26, 2013, pp. 22297–300.
- 236 Cox testimony, August 26, 2013, pp. 22300–2.
- 237 Gillespie testimony, September 3, 2013, pp. 23542–3.
- 238 Gillespie testimony, September 3, 2013, pp. 23543–7.
- 239 Gillespie testimony, September 3, 2013, pp. 23544–52.
- 240 Cox testimony, August 26, 2013, p. 22310.
- 241 Cox testimony, August 26, 2013, pp. 22312–13.
- 242 Jollymore testimony, September 23, 2013, pp. 26821–4.
- 243 Jollymore testimony, September 23, 2013, pp. 26824–5.
- 244 Jollymore testimony, September 23, 2013, pp. 26830–2.
- 245 Jollymore testimony, September 23, 2013, pp. 26831–3.
- 246 Kerr testimony, September 25, 2013, pp. 27287–99.
- 247 Jollymore testimony, September 23, 2013, pp. 26834–5.
- 248 Jollymore testimony, September 23, 2013, pp. 26835–6.
- 249 Jollymore testimony, September 23, 2013, pp. 26836–7.
- 250 See, as well, Chambers testimony, September 18, 2013, pp. 26073–5.
- 251 Chambers testimony, September 18, 2013, p. 26076.
- 252 Exhibit 8025; Officer testimony, August 21, 2013, p. 21608.
- 253 Officer testimony, August 21, 2013, p. 21582.
- 254 Officer testimony, August 21, 2013, pp. 21582–3 and 21600–1; Exhibit 8025.
- 255 Officer testimony, August 21, 2013, pp. 21605–6.
- 256 Chambers testimony, September 18, 2013, pp. 26064–6.
- 257 Chambers testimony, September 18, 2013, pp. 26068–70 and 26222.
- 258 Chambers testimony, September 18, 2013, pp. 26231–2.
- 259 Chambers testimony, September 18, 2013, pp. 26069–70.
- 260 Chambers testimony, September 18, 2013, pp. 26223–8.
- 261 Exhibit 6413; Chambers testimony, September 18, 2013, p. 26076. “District coordinator informed” is a reference to the district coordinator for the mutual aid program: Chambers testimony, September 18, 2013, p. 26077.
- 262 Exhibit 6413.
- 263 Chambers testimony, September 18, 2013, pp. 26077–8.
- 264 Exhibit 6426; Chambers testimony, September 18, 2013, pp. 26078–80.
- 265 Chambers testimony, September 18, 2013, p. 26081.
- 266 Chambers testimony, September 18, 2013, p. 26083.
- 267 Exhibit 6426; Chambers testimony, September 18, 2013, pp. 26080–5.
- 268 Chambers testimony, September 18, 2013, pp. 26097–104; Exhibit 6434; Officer testimony, August 21, 2013, pp. 21619–20; Exhibit 6585.
- 269 deBortoli testimony, October 7, 2013, p. 28392; Exhibit 8114.
- 270 Hefkey testimony, October 8, 2013, pp. 28601–3.
- 271 Chambers testimony, September 18, 2013, pp. 26103–5; Exhibit 6436.
- 272 Exhibit 6451; Chambers testimony, September 18, 2013, pp. 26111–14.
- 273 Exhibit 6464.
- 274 Neadles testimony, September 10, 2013, pp. 25256–7.
- 275 Exhibit 8128.
- 276 Exhibit 6483; Chambers testimony, September 18, 2013, pp. 26114–15.
- 277 Exhibit 3743, p. 006; deBortoli testimony, October 7, 2013, p. 28417.
- 278 Exhibit 6499.
- 279 Exhibit 6501.
- 280 Exhibit 6501.
- 281 Chambers testimony, September 18, 2013, pp. 26116–18.
- 282 Exhibit 6504; Chambers testimony, September 18, 2013, pp. 26118–19.
- 283 Exhibit 6515; Neadles testimony, September 10, 2013, pp. 25261–3. The photos in question are Exhibits 9585 and 9586.
- 284 Exhibit 6555.
- 285 Exhibit 9232, p. 008; Chambers testimony, September 18, 2013, pp. 26119–22.
- 286 Exhibit 6571.
- 287 Chambers testimony, September 18, 2013, pp. 26124–5.
- 288 Exhibit 3743, p. 012.
- 289 Exhibit 6596.
- 290 Neadles testimony, September 10, 2013, pp. 25271–2.
- 291 Exhibit 6604; Neadles testimony, September 10, 2013, p. 25273.
- 292 Exhibit 7812.
- 293 Hefkey testimony, October 8, 2013, pp. 28599–601.
- 294 O’Leary testimony, September 17, 2013, pp. 25848–9.
- 295 Exhibit 8121; Exhibit 8119; O’Leary testimony, September 17, 2012, pp. 25842–3.
- 296 Exhibit 6348; O’Leary testimony, September 17, 2013, pp. 25848–9.
- 297 I discuss Mr. Jeffreys’s qualifications in detail below.
- 298 Jeffreys testimony, October 3, 2013, pp. 28068–70.
- 299 Jeffreys testimony, October 3, 2013, pp. 28070–1.
- 300 Jeffreys testimony, October 3, 2013, pp. 28069–70, and 28072; Exhibit 9449, p. 731.
- 301 Jeffreys testimony, October 3, 2013, pp. 28072–4.
- 302 Exhibit 9449; Jeffreys testimony, October 3, 2013, pp. 28074–7.
- 303 Jeffreys testimony, October 3, 2013, pp. 28077–8; Exhibit 9449.
- 304 Exhibit 7020; Jones testimony, September 26, 2013, pp. 27386–7.
- 305 Jones testimony, September 26, 2013, pp. 27377–9.
- 306 Exhibit 6385; Lacroix testimony, October 3, 2013, pp. 27963–9.
- 307 Jones testimony, September 26, 2013, pp. 27379–84.
- 308 Lacroix testimony, October 3, 2013, pp. 27969–74; Exhibit 6385; Jones testimony, September 26, 2013, pp. 27378–9.
- 309 Jeffreys testimony, October 3, 2013, pp. 28032–6.
- 310 Jeffreys testimony, October 3, 2013, pp. 28032–6.
- 311 Jeffreys testimony, October 3, 2013, p. 28037.
- 312 Jeffreys testimony, October 3, 2013, pp. 28037–40, 28042.
- 313 Jeffreys testimony, October 3, 2013, pp. 28037–40, 28042.
- 314 Jeffreys testimony, October 3, 2013, pp. 28040–1.
- 315 Jeffreys testimony, October 3, 2013, pp. 28041–2.
- 316 Jeffreys testimony, October 3, 2013, pp. 28055–6.
- 317 Jeffreys testimony, October 3, 2013, pp. 28042–4.
- 318 Sanders testimony, October 4, 2013, pp. 28270–2.
- 319 Jones testimony, September 26, 2013, pp. 27374–7.
- 320 Lacroix testimony, October 3, 2013, pp. 27946–9.
- 321 Lacroix testimony, October 3, 2013, p. 27948.
- 322 Jeffreys testimony, October 3, 2013, pp. 28049–50.
- 323 Jeffreys testimony, October 3, 2013, p. 28045.
- 324 Jeffreys testimony, October 3, 2013, pp. 28046–9.
- 325 Jeffreys testimony, October 3, 2013, pp. 28045–6.
- 326 Jeffreys testimony, October 3, 2013, pp. 28050–1.



- <sup>327</sup> Jeffreys testimony, October 3, 2013, pp. 28051–2.
- <sup>328</sup> Jeffreys testimony, October 3, 2013, p. 28056.
- <sup>329</sup> Jeffreys testimony, October 3, 2013, p. 28057.
- <sup>330</sup> Jeffreys testimony, October 3, 2013, pp. 28058–61.
- <sup>331</sup> Jeffreys testimony, October 3, 2013, pp. 28061–2.
- <sup>332</sup> Jeffreys testimony, October 3, 2013, pp. 28059–60.
- <sup>333</sup> Exhibit 245.
- <sup>334</sup> Jeffreys testimony, October 3, 2013, p. 28064.
- <sup>335</sup> Jeffreys testimony, October 3, 2013, pp. 28064–6.
- <sup>336</sup> Sanders testimony, October 4, 2013, pp. 28272–5.
- <sup>337</sup> Sanders testimony, October 4, 2013, pp. 28275–7.
- <sup>338</sup> Jones testimony, September 26, 2013, pp. 27428–9.
- <sup>339</sup> Jones testimony, September 26, 2013, pp. 27439–45.
- <sup>340</sup> Lacroix testimony, October 3, 2013, pp. 27953–9.
- <sup>341</sup> Lacroix testimony, October 3, 2013, pp. 27958–63.
- <sup>342</sup> Lacroix testimony, October 3, 2013, pp. 27976–7.
- <sup>343</sup> Exhibit 3743, pp. 006–7; Exhibit 6396.
- <sup>344</sup> Exhibit 6180, p. 808.
- <sup>345</sup> Exhibit 6396.
- <sup>346</sup> deBortoli testimony, October 7, 2013, p. 28418; Exhibit 3743, p. 006; Exhibit 6396; Exhibit 6180, p. 808.
- <sup>347</sup> Exhibit 6499.
- <sup>348</sup> Thomas testimony, August 15, 2013, pp. 21081–4.
- <sup>349</sup> Thomas testimony, August 15, 2013, pp. 21084–5.
- <sup>350</sup> Jones testimony, September 26, 2013, pp. 27393–4.
- <sup>351</sup> Jones testimony, September 26, 2013, pp. 27394–5.
- <sup>352</sup> Gillespie testimony, September 3, 2013, p. 23565.
- <sup>353</sup> Exhibit 6662.
- <sup>354</sup> Neadles testimony, September 10, 2013, pp. 25274–6.
- <sup>355</sup> Chambers testimony, September 18, 2013, pp. 26133–4.
- <sup>356</sup> Exhibit 6674.
- <sup>357</sup> Exhibit 6674.
- <sup>358</sup> Exhibit 8025.
- <sup>359</sup> Exhibit 6619; Officer testimony, August 21, 2013, pp. 21666–7.
- <sup>360</sup> Officer testimony, August 21, 2013, pp. 21666–8.
- <sup>361</sup> Officer testimony, August 22, 2013, pp. 21701–2, and 21903–4.
- <sup>362</sup> Exhibit 8025; Officer testimony, August 21, 2013, p. 21667.
- <sup>363</sup> Exhibit 6619.
- <sup>364</sup> Lacroix testimony, October 3, 2013, pp. 27975–6; Jeffreys testimony, October 3, 2013, p. 28077–8; Exhibit 6385, p. 160.
- <sup>365</sup> Officer testimony, August 22, 2013, pp. 21905–6.
- <sup>366</sup> Exhibit 6690.
- <sup>367</sup> Neadles testimony, September 10, 2013, pp. 25178–83.
- <sup>368</sup> Neadles testimony, September 10, 2013, pp. 25183–4.
- <sup>369</sup> Neadles testimony, September 10, 2013, pp. 25188–9.
- <sup>370</sup> Neadles testimony, September 10, 2013, pp. 25190–1.
- <sup>371</sup> Neadles testimony, September 10, 2013, pp. 25190–2.
- <sup>372</sup> Neadles testimony, September 10, 2013, pp. 25201–2.
- <sup>373</sup> Neadles testimony, September 10, 2013, pp. 25194–7.
- <sup>374</sup> Neadles testimony, September 10, 2013, pp. 25207–8.
- <sup>375</sup> Neadles testimony, September 10, 2013, p. 25212.
- <sup>376</sup> Neadles testimony, September 10, 2013, pp. 25187–8.
- <sup>377</sup> Comella testimony, September 4, 2013, p. 23891.
- <sup>378</sup> Comella testimony, September 4, 2013, pp. 23893–6.
- <sup>379</sup> Comella testimony, September 4, 2013, pp. 23893–4.
- <sup>380</sup> Comella testimony, September 4, 2013, pp. 23895–8.
- <sup>381</sup> Comella testimony, September 4, 2013, pp. 23963–4.
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- <sup>384</sup> Comella testimony, September 4, 2013, pp. 23920–2.
- <sup>385</sup> Exhibit 9278.
- <sup>386</sup> Comella testimony, September 4, 2013, pp. 24032–4.
- <sup>387</sup> McCallion testimony, September 6, 2013, p. 24444.
- <sup>388</sup> McCallion testimony, September 6, 2013, p. 24446.
- <sup>389</sup> McCallion testimony, September 6, 2013, p. 24453.
- <sup>390</sup> McCallion testimony, September 6, 2013, p. 24449.
- <sup>391</sup> McCallion testimony, September 6, 2013, pp. 24474–5.
- <sup>392</sup> McCallion testimony, September 6, 2013, p. 24473.
- <sup>393</sup> McRae testimony, September 25, 2013, pp. 27164–5.
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- <sup>395</sup> McRae testimony, September 25, 2013, p. 27170.
- <sup>396</sup> McRae testimony, September 25, 2013, p. 27172.
- <sup>397</sup> McRae testimony, September 25, 2013, p. 27171.
- <sup>398</sup> Guy testimony, September 24, 2013, pp. 27038–46.
- <sup>399</sup> Guy testimony, September 24, 2013, pp. 27046–7.
- <sup>400</sup> Sorel testimony, October 1, 2013, pp. 27533–7.
- <sup>401</sup> Fowlds testimony, September 19, 2013, pp. 26284–5.
- <sup>402</sup> Fowlds testimony, September 19, 2013, p. 26296.
- <sup>403</sup> Fowlds testimony, September 19, 2013, pp. 26284–5.
- <sup>404</sup> Glavin testimony, October 1, 2013, pp. 27633–6.
- <sup>405</sup> Glavin testimony, October 1, 2013, pp. 27638–9.
- <sup>406</sup> Cranford testimony, September 9, 2013, pp. 24720–3.
- <sup>407</sup> Cranford testimony, September 9, 2013, pp. 24725–7.
- <sup>408</sup> Feldman testimony, September 18, 2013, pp. 26004–5; Exhibit 1087.
- <sup>409</sup> Feldman testimony, September 18, 2013, pp. 26005–8.
- <sup>410</sup> Neadles testimony, September 12, 2013, pp. 25568–71.
- <sup>411</sup> Neadles testimony, September 10, 2013, pp. 25238–9.
- <sup>412</sup> Exhibit 6250.
- <sup>413</sup> Neadles testimony, September 10, 2013, pp. 25243–4.
- <sup>414</sup> Exhibit 6250.
- <sup>415</sup> Exhibit 6250.
- <sup>416</sup> Exhibit 6393.
- <sup>417</sup> McRae testimony, September 25, 2013, pp. 27179–80.
- <sup>418</sup> Exhibit 6393.
- <sup>419</sup> McRae testimony, September 25, 2013, pp. 27180–3.
- <sup>420</sup> Exhibit 7817.
- <sup>421</sup> Exhibit 6251.
- <sup>422</sup> Neadles testimony, September 10, 2013, pp. 25248–9.
- <sup>423</sup> McRae testimony, September 25, 2013, pp. 27180–1.
- <sup>424</sup> McRae testimony, September 25, 2013, pp. 27184–6.
- <sup>425</sup> Exhibit 6393.
- <sup>426</sup> McRae testimony, September 25, 2013, pp. 27183–5.
- <sup>427</sup> McRae testimony, September 25, 2013, pp. 27187–9.
- <sup>428</sup> Sorel testimony, October 1, 2013, pp. 27545–6.
- <sup>429</sup> Sorel testimony, October 1, 2013, pp. 27595–6.
- <sup>430</sup> Sorel testimony, October 1, 2013, pp. 27547–8.
- <sup>431</sup> Guy testimony, September 24, 2013, pp. 27054–5.
- <sup>432</sup> Guy testimony, September 24, 2013, p. 27059.
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- <sup>434</sup> Exhibit 6393.
- <sup>435</sup> Sorel testimony, October 1, 2013, pp. 27596–8.
- <sup>436</sup> Comella testimony, September 4, 2013, pp. 24062–3.
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- <sup>438</sup> McRae testimony, September 25, 2013, p. 27196.
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- <sup>441</sup> Guy testimony, September 24, 2013, pp. 27059–60.
- <sup>442</sup> McRae testimony, September 25, 2013, pp. 27190–3.
- <sup>443</sup> Guy testimony, September 24, 2013, pp. 27056–7.
- <sup>444</sup> Exhibit 6393.
- <sup>445</sup> Exhibit 6250.
- <sup>446</sup> Exhibit 6393.
- <sup>447</sup> McRae testimony, September 25, 2013, p. 27205.
- <sup>448</sup> Fowlds testimony, September 19, 2013, p. 26313.
- <sup>449</sup> Sorel testimony, October 1, 2013, pp. 27550–3.
- <sup>450</sup> Feldman testimony, September 18, 2013, pp. 26010–3.
- <sup>451</sup> McRae testimony, September 25, 2013, p. 27207.
- <sup>452</sup> Cornella testimony, September 4, 2013, pp. 24071–2.
- <sup>453</sup> Exhibit 6464.
- <sup>454</sup> Exhibit 6485.
- <sup>455</sup> Exhibit 6457.
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- <sup>457</sup> Exhibit 6500.
- <sup>458</sup> Exhibit 6503.
- <sup>459</sup> Exhibit 6537.
- <sup>460</sup> Cranford testimony September 9, 2013, p. 24741.
- <sup>461</sup> Needles testimony September 10, 2013 pp. 25263 –4.
- <sup>462</sup> Exhibit 6515.
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## June 24

During the evidence heard in this phase of the Inquiry, the witnesses relived their experience through what I referred to during the hearings as the “fog of war.” The recollection of a number of the rescuers about when events occurred or things were done differed from one witness to the next. The difficulty was compounded by the fact that many rescuers failed to take any notes or only took limited notes during the deployment. Scribes were not designated to undertake that function. Time, of course, was of the essence throughout. Tension, emotion, and fatigue took their toll. Consequently, I did not find it unusual that the rescuers had difficulty recalling certain events when they appeared before me; better notes would certainly have assisted in bridging gaps and reviving lost recollections. I have done my best to piece together the events in the minutes, hours, and days following the collapse in order to present as accurate a narrative as possible of the response and of the efforts to rescue those trapped beneath the rubble pile.

### Roger Jeffreys, structural engineer with the Ministry of Labour, arrives and surveys the damage

Roger Jeffreys, the provincial engineer with the Ministry of Labour, did not arrive in Elliot Lake until 12:30 a.m. on the morning of June 24; Donald Jones and Michel Lacroix, both inspectors with the ministry, had arrived earlier.<sup>1</sup> Mr. Jeffreys met with Mr. Jones and Mr. Lacroix and was then taken to the Mall at about 12:45 a.m. and introduced to Chief Paul Officer of the Elliot Lake Fire Department and Sgt. Jamie Gillespie with the Ontario Provincial Police UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear and Explosive Response Team). Mr. Jeffreys testified that he explained to them that he was a structural engineer and that he was there to provide whatever assistance he could. After the introductions, he and Sgt. Gillespie walked around the Mall to determine the structural stability of the remaining structure.<sup>2</sup> Mr. Jeffreys recalled that he was provided with copies of the steel shop drawings<sup>3</sup> but did not recall being given a copy of the Mall’s structural drawings at the time of his arrival, although he was provided with them and other drawings later.<sup>4</sup>

The inspection of the Mall started on the roof, which was accessed through Zellers. Mr. Jeffreys testified that he walked back and forth along the rooftop, first in an east–west direction and then in a south–north direction,

looking for structural issues and evidence of recent cracks.<sup>5</sup> He also entered the penthouse area, which enclosed the stairs and escalator leading down into the Mall; there he noted a crack in the floor at the top of the stairs.<sup>6</sup> The expansion of this crack would later become a determining factor in the decision to stop the rescue efforts and clear the rescuers out of the Mall.

Following his review of the rooftop area, he re-entered the Mall through Zellers and proceeded to inspect the upper level. He and Sgt. Gillespie arrived on the west side of the collapse area where Mr. Jeffreys noted a lot of material hanging down from the ceiling, such as tiles, ductwork, and piping. He did not venture

further because of these overhead hazards. He also noted cracking of the hollow core slabs to the west of the collapse area, which he identified as a potential area of subsequent collapse.<sup>7</sup> The inspection proceeded through the east–west corridor running along the northern edge of the building, east to the back door of Dollarama into the food court. Overhead hanging hazards were also noted in this area.<sup>8</sup>

While in the food court, Mr. Jeffreys noted a column located to the west of the collapse area. The drawings he reviewed had shown an expansion joint in that area. Mr. Jeffreys wanted to confirm that the as-built conditions matched the information shown in the drawings. The tiles and drywall covering the column were removed by

**The expansion of this crack would later become a determining factor in the decision to stop the rescue efforts and clear the rescuers out of the Mall.**



OPP Cst. Steve Hulsman to allow Mr. Jeffreys to confirm whether the columns were “twinned” – meaning two columns side-by-side.<sup>9</sup> The inspection revealed that there was indeed a twinned column in that area; this fact provided a level of comfort to Mr. Jeffreys. He was able to determine that the hollow core slabs were supported on the westerly end by a separate beam. This bolstered his confidence in the stability of that particular area of the Mall.<sup>10</sup>

Mr. Jeffreys also looked at the beam supporting the bottom of the escalator. He noted that this beam was also supporting the second floor of the Mall and was “noticeably bowed.”<sup>11</sup> Mr. Jeffreys identified the bow as an indication of significant structural distress in that area (see fig. 2.4.1).<sup>12</sup>

### **Mr. Jeffreys and Sgt. Gillespie discuss options to stabilize the beam under the escalator**

Following the inspection, Sgt. Gillespie and Mr. Jeffreys discussed methods of stabilizing the beam under the escalator. They pondered a plan to shore up the beam and the pedestrian walkways around it with laced-post shores.<sup>13</sup> It was recognized that this task would not be easy because of the location of the beam in relation to the escalator and the concrete slabs resting on top (see fig. 2.4.2). There were many hazards in the area, much debris, and an excessive load was stressing the beam. Sgt. Gillespie testified that he suggested putting larger wooden T-post-style shores or multi-post configurations to support the beam. Mr. Jeffreys was having difficulty assessing the weight of the load on the escalator and did not believe lumber would be sufficient. Consequently, Capt. John Thomas of the Elliot Lake Fire Department was asked to determine the availability of steel shores for support.<sup>14</sup>

A plan was devised at that point by Mr. Jeffreys and Sgt. Gillespie that included shoring the beam with steel. Cst. Patrick Waddick was assigned this task because of his experience as a welder before joining the OPP. Sgt. Gillespie testified that he instructed Cst. Waddick to find out from Mr. Jeffreys the type of steel required. Steel shores were ultimately obtained as well as steel jack posts (similar to those installed in the basements of residential homes). Sgt. Gillespie acknowledged that the installation of steel shores was not standard procedure; however, given Cst. Waddick’s background, he did not see an issue with proceeding in this manner. It was determined that the operation would have to be very controlled because it would be difficult to clear the debris, and it would also be risky given the massive amount of weight directly overhead.<sup>15</sup>



**Figure 2.4.1 Bow in beam under the escalator**

Source Exhibit 6226



**Figure 2.4.2 Debris on escalator**

Source Exhibit 7294

Although it had been decided that shoring the beam under the escalator would make it safer and would provide an entry and exit point onto the debris pile from the south, the work was ultimately never carried out.<sup>16</sup> As discussed below, this plan was discarded with the arrival of the Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3). The members of the team disagreed with the decision to proceed in this manner because they felt it was not feasible.

## **The rescue efforts continue**

### **The Elliot Lake Fire Department provides the logistics**

In the early morning hours of June 24, the Elliot Lake Fire Department continued to set up logistics for the site while awaiting the arrival of HUSAR/TF3. Capt. Thomas testified that they were trying to determine the workforce available within the department and addressing issues like lighting, food, washrooms, and scene security.<sup>17</sup>

Capt. Thomas took over incident command from Chief Officer at 2:51 a.m. to allow him to return home to clean up.<sup>18</sup> By this time, HUSAR/TF3 had still not arrived and those on the scene continued to prepare for its arrival. Capt. Thomas confirmed that he had been asked by UCRT to obtain steel and he was making those arrangements. At this point only UCRT was at the Mall, setting up, taking air samples, and assessing the situation.<sup>19</sup>

### **In the early hours of June 24, UCRT starts to develop an incident action plan**

At 1:10 a.m., Cst. Ryan Cox was continuing his initial evaluation of the situation. At that point he was aware that HUSAR/TF3 was on its way with 34 of its members. Although he knew they would be present, he had not yet determined how HUSAR/TF3 would mesh into any plan he developed.<sup>20</sup> His expectation was that the two teams would divide their respective resources; part of the HUSAR/TF3 members would join the UCRT team for one shift and the balance of the HUSAR/TF3 team would form the other shift. These two groups had worked together previously without any issues. "That was the – the expectation, that we would just kind of divide and conquer, so to speak."<sup>21</sup>

### **The Mall's 22 surveillance cameras are seized by the OPP**

During the OPP's inspection of the scene, it was discovered that the Mall had a surveillance system and that the cameras had been in operation at the time of the collapse. At 1:50 a.m., 22 cameras were seized from the Mall, secured by Det. Cst. Richard Eady and taken to the Elliot Lake OPP detachment. Cst. Dale Burns, the OPP identification officer, testified that the video footage was not extracted from the cameras until June 26.<sup>22</sup>

The cameras and the recording system were seized in the hope that there would be video footage of what happened in the moments immediately before the collapse. Cst. Burns testified that he did not know whether anyone within the OPP advised HUSAR/TF3 about the contents of the video and he did not recall providing Staff Insp. William Needles with videos. He acknowledged that the videos contained important information about the location of the victims at the time of the collapse. Cst. Burns was unable to provide any information regarding the decision on whether and when to provide the videos to Staff Insp. Needles. That decision would have been made by someone of a higher rank.<sup>23</sup>

Cst. Waddick testified that he had seen the video footage and that it confirmed that at least two people were trapped beneath the rubble pile. He could not recall when he had seen the video but recalled being in the area of the command post when it was shown. He believed everyone was aware that surveillance footage of the Mall



was available. He agreed that the footage should have been shared with HUSAR/TF3 command and the incident commander; it was his understanding that everyone had been aware of it.<sup>24</sup>

Cst. Waddick believed that he viewed the video on Sunday morning. He testified that the video showed a young woman facing an older woman who was purchasing lottery tickets immediately prior to the collapse.<sup>25</sup> He acknowledged that he may have been mistaken about the date on which he saw the surveillance footage, because he had seen it only briefly and had not recorded it in his notes. He was prepared to accept the evidence of Cst. Burns and Staff Insp. Needles that the videos were not available until Monday, June 25, as opposed to Sunday morning as he had recalled.<sup>26</sup>

Chief Officer was aware the cameras had been seized from the Mall. He testified that at the time, he was under the impression that he would be advised of the outcome of the review of the footage. He admitted that he did not ask at any point during the rescue efforts to see the videos.<sup>27</sup> He was advised that HUSAR/TF3 had seen the videos in the afternoon of June 25.<sup>28</sup>

The seized video cameras should have been brought to the attention of Staff Insp. Needles and anyone else in a command position. Obtaining the footage should have been high on the list of tasks to be completed because the video was ultimately shown to contain vital information regarding the number of persons trapped and their approximate location within the rubble pile.

Once the footage had been retrieved, the OPP should have taken steps to organize a viewing and ensure that all those in command were provided with the information. The fact that not everyone had seen the footage is an example of the lack of communication and coordination that plagued this rescue and about which I will be commenting in more detail below.

**The fact that not everyone had seen the footage is an example of the lack of communication and coordination that plagued this rescue ...**

### **The false rumour that the Ministry of Labour had stopped the rescue persists**

I have already discussed how rumours developed on June 23 that the Ministry of Labour had somehow shut down the rescue scene. Those rumours persisted in some circles. Staff Insp. Needles, in particular, repeatedly adopted and reiterated them in his communications.

Carol-Lynn Chambers, manager, Emergency Planning, Office of the Fire Marshal, continued to refer to the rumours in one of her internal email updates to that office. At 1:28 a.m., she sent an email advising:

OPP UCRT continuing to search through high angle to place cameras and, equipment.

TO HUSAR [Toronto Heavy Urban Search and Rescue] continues en route.

Potential intervention by MOL [Ministry of Labour] to halt rescue ops was reported by media but it was subsequently confirmed by OFM [Office of the Fire Marshal] from the IC (Fire Chief) that the MOL is continuing to cooperate at this time during the ongoing RESCUE phase.<sup>29</sup>

James Cranford, the engineer with the HUSAR/TF3 team, also recalled hearing that the Ministry of Labour had indicated that no one should be in the Mall. He could not recall when he received this information but was confident that it was fairly soon after he arrived at the scene with HUSAR/TF3 at 4:30 a.m.<sup>30</sup> He testified that, after his arrival, he spoke with Mr. Jeffreys who stated that the building was unsafe and that he had asked people not to work in it until it could be further assessed. However, Mr. Cranford was not aware of any formal order being issued.<sup>31</sup>



### **Staff Insp. Neadles is the only one from HUSAR/TF3 who continues to believe that the Ministry of Labour has stopped the rescue**

In the morning of June 24, the media continued to report that the Ministry of Labour needed to assess safety before it would allow the rescue to continue, giving the impression to the public that the ministry was interfering. At 8:19 a.m., Ms. Chambers sent an email to Staff Insp. Neadles to inquire whether the media reports were old or new. Staff Insp. Neadles confirmed by email (8:48 a.m.) that it was in fact old news because the ministry had approved HUSAR/TF3's operations plan, and he replied: "Yes it is. We have our OPS plan approved. They will be back!! Comella schmoozed them!!"<sup>32</sup>

Capt. Tony Comella was asked about the statements made in Staff Insp. Neadles's email, and he testified that he did not know what they meant. He did not believe that he sold the ministry on anything and, to the contrary, had been struck by Mr. Jeffreys's positive attitude and his willingness to assist when he (Comella) first arrived on the scene.<sup>33</sup>

In his first email update sent to Ms. Chambers and others within the Office of the Fire Marshal, Staff Insp. Neadles had specifically stated:

Ministry of Labour who originally cleared the site of all workers has approved our Operational plan that should take an estimated 24 hours to complete. They will return to discuss the next move.<sup>34</sup>

When questioned about the information he had provided, Staff Insp. Neadles retreated somewhat from the statement in his email and indicated that he had initially been led to believe that the Ministry of Labour had removed rescuers from the site. He never identified who provided him with this information and said that he later learned that this information was not accurate.<sup>35</sup> He acknowledged that the reference to the approval of the operational plan by the ministry was misleading because it did not approve the plan. He stated that he received information throughout the deployment which ultimately turned out to be untrue and which led to many inaccurate updates.<sup>36</sup> He did not elaborate on these inaccuracies. He took no steps to confirm the authenticity of the information before disseminating it to others.

Capt. Comella testified that he did not understand why the Ministry of Labour was at the scene and stated:

At the time, I didn't really understand what the purpose was, but he did ask me ... what I felt about his ability as a Ministry of Labour representative on scene and I remember having the conversation with him that as long as it's a rescue, he has no jurisdiction as far as I was concerned. But we absolutely welcomed his help, if he was willing to do that.<sup>37</sup>

Although he may not have understood the purpose or reason for the ministry's presence at the scene, Capt. Comella disagreed with the contents of the 8:48 a.m. email sent by Staff Insp. Neadles to Ms. Chambers (although he did not receive this email at the time it was sent and only learned of its existence after the deployment). He testified that he was unaware that the Ministry of Labour had cleared the site and that he would not describe Mr. Jeffreys's involvement as an approval of the operational plan. Rather, he described it as a consensus among all those involved in the assessment of the scene.<sup>38</sup> From his perspective, it was not necessary for HUSAR/TF3 to obtain approval from the Ministry of Labour for the operational plan. Capt. Comella believed that Mr. Jeffreys had removed his ministry hat, and was part of the team assessing the scene, and was genuinely looking to help out as a structural engineer and not as a Ministry of Labour representative.<sup>39</sup>

Site Cmdr. Michael McCallion's evidence on the subject was essentially the same as that of Capt. Comella.<sup>40</sup>

### **The Ministry of Labour denies stopping the rescue efforts**

Mr. Jeffreys was emphatic in his evidence that the Ministry of Labour never cleared the site of any rescuers and he was unaware of the inspectors, Messrs. Jones and Lacroix, having done so. Mr. Jeffreys contradicted the contents of the 8:48 a.m. email sent by Staff Insp. Needles. He testified that he had not approved a plan nor had he represented or given the impression to Staff Insp. Needles that he was providing any such approval. He could not explain how Staff Insp. Needles garnered his belief. He disagreed that they were to get together to discuss the next move.<sup>41</sup>

Again, I note that false information continued to circulate on June 24 that the Ministry of Labour had halted the rescue and that MOL approval was somehow required to continue. Staff Insp. Needles, in particular, continued to promulgate this false message when, as HUSAR/TF3 incident commander, he ought to have verified the source of this important information and prevented the misinformation that led to confusion and wasted time. All he needed to do was ask Mr. Jeffreys or the ministry inspectors. Better communications between the ministry and the Office of the Fire Marshal would have squelched the rumour. A modicum of information about the purpose of the ministry's presence on scene would have sufficed.

### **HUSAR/TF3 arrives in Elliot Lake**

At 4:18 a.m. on June 24, HUSAR/TF3 arrived in Elliot Lake, more than 12 hours after the collapse.<sup>42</sup>

Capt. Comella was the first person to arrive at the Mall.<sup>43</sup> Prior to his arrival, he had received a few photographs from Sgt. Gillespie and had been involved in a few telephone calls with Sgt. Gillespie and Staff Insp. Needles.<sup>44</sup> At the time of his arrival, his information was that between six and 30 people were believed to be trapped in the collapse; this number had fluctuated while the team was making its way up to Elliot Lake. Capt. Comella also testified that he was aware that the fire department and a paramedic had already determined there was one death.<sup>45</sup>

Capt. Thomas, the incident commander when HUSAR/TF3 arrived, spoke with Capt. Comella and Capt. Martin McRae. He explained that he was incident commander at that moment because Chief Officer was away from the scene. He was provided with information about the equipment HUSAR/TF3 had brought and the personnel that was available. Capt. Thomas updated them on the fact that one victim was confirmed as deceased and that contact previously established with a second potential victim had been lost.<sup>46</sup>

### **HUSAR/TF3 does not assign anyone to head up the Planning Section**

Staff Insp. Needles notified Ms. Chambers that HUSAR/TF3 had arrived in Elliot Lake. However, he failed to advise her that they did not have a designated planning person as part of the deployment. Division Chief Doug Silver, the person who would normally have occupied that function, was attending federal funding discussions in Ottawa and was not able to deploy to Elliot Lake. Ms. Chambers testified that she would have expected someone to be assigned to that position. She explained that the Office of the Fire Marshal provides support to HUSAR/TF3 in a response but it cannot provide the planning function. In any event, no assistance was requested.<sup>47</sup>

Ms. Chambers agreed it was possible that, in the absence of Division Chief Silver, the next best option available to Staff Insp. Needles would have been to operate the Planning Section by committee, a less satisfactory expedient.<sup>48</sup>

Capt. Comella took on the lion's share of the planning. This fact is addressed later in this chapter. No attempt appears to have been made to inquire of Sgt. Gillespie if UCRT had anyone who could act as chief of planning. Both teams arrived in Elliot Lake with less than their full complement. Lack of coordination between them left that essential position vacant, leading to problems during the response.

## Chain of command

It quickly became clear to me that the normal chain of command integral to the Incident Management System (IMS) was not respected during the Elliot Lake deployment. Under IMS, Chief Officer, as overall incident commander, should have had the final say on all decisions. He did not. Staff Insp. Neadles quickly took over and made decisions without consulting or seeking approval from Chief Officer. It appears to me that Chief Officer did not have a proper understanding of his role until much later in the response; to a certain extent he tacitly handed over the reins to Staff Insp. Neadles.

### Chief Officer's knowledge and understanding of the chain of command

Chief Officer testified that in the early morning hours of June 24, prior to HUSAR/TF3's arrival, he considered the operation as a unified command, with each agency having its own incident commander. The agencies present at that time were Emergency Medical Services and OPP.<sup>49</sup>

Chief Officer testified that, after HUSAR/TF3 arrived, he treated Staff Insp. Neadles as the overall rescue incident commander.<sup>50</sup> Initially he perceived HUSAR/TF3 as being an outside agency and Staff Insp. Neadles as incident commander of that section. Chief Officer learned from Bob Thorpe, several days after the collapse, that Staff Insp. Neadles was in fact working for him (Officer).<sup>51</sup>

Chief Officer also testified that he had a discussion with Cst. Cox about the role of UCRT because he did not understand how everything was going to work. Cst. Cox explained to him that, when both teams respond together, UCRT integrates with HUSAR/TF3 and is used and directed by HUSAR/TF3. Chief Officer testified that Cst. Cox indicated to him that UCRT did not like this arrangement but accepted it. Chief Officer testified that he did not necessarily understand the structure but he accepted it, and from his perspective his main interest was ensuring that he received the help he required. The organizational relationship as explained by Cst. Cox prevailed for the entire time the two teams were present on the scene.<sup>52</sup> Sgt. Gillespie testified that, although HUSAR/TF3 was on the scene, it was his understanding and belief that incident command was to remain at the local level with Chief Officer.<sup>53</sup>

Chief Officer testified that, when HUSAR/TF3 arrived in Elliot Lake, he went to the scene and handed it control and planning of the rescue. The Fire Department remained on site in order to provide accountability and logistics and to assist HUSAR/TF3 wherever and however it could.<sup>54</sup> It had been Chief Officer's expectation that on arrival HUSAR/TF3 would be in charge of the rescue.<sup>55</sup> Throughout the operation, Chief Officer consulted with that team on all the decision making related to the rescue. He did not consult with the UCRT team.<sup>56</sup> Chief Officer confirmed that he was the incident commander and that the IMS provides that the incident commander is to approve the incident action plan. Although he was the incident commander, Chief Officer confirmed that he gave Staff Insp. Neadles "free rein of the rescue." From his perspective, HUSAR/TF3 personnel knew what they were doing. Chief Officer testified that no one sought his approval and he did not give his approval to the incident action plan. He explained that he was updated about ongoing actions but he was not provided with great detail in terms of the way responders were going to perform their operation.<sup>57</sup>

Chief Officer testified that he maintained overall control and command, but that HUSAR/TF3 was in charge of the rescue sector and the Fire Department was supporting its needs by doing logistics, accountability, and any other role that Staff Insp. Neadles could not staff.<sup>58</sup>



Chief Officer testified that he did not become aware of what the true command structure should have been, and more specifically that Staff Insp. Neadles was to have reported to him, until June 25 when he learned that the rescuers would not be going back in the Mall.<sup>59</sup> Chief Officer qualified his answer and stated that, when Staff Insp. Neadles had indicated that he was turning the scene back over to him, he did not take that statement to mean that he had lost command of the site. He testified that he always believed he had command of the site and it was never an issue. He explained that he had the overall authority but Staff Insp. Neadles was the lead or sector officer for the rescue portion. Staff Insp. Neadles would have had full control over that portion. On June 24 and June 25, while the rescue efforts were continuing, there was never a challenge on who had the scene.<sup>60</sup>

Capt. Thomas testified that, based on his training with the IMS, it was his belief and understanding that the Mall collapse continued to be the Elliot Lake Fire Department's responsibility and that HUSAR/TF3 and OPP UCRT were there to assist it. He also understood that Chief Officer was to maintain the decision-making power.<sup>61</sup>

### **The view of others as to who was in command and control**

Mr. Jeffreys testified that, although no one specifically told him, he perceived Staff Insp. Neadles as being in charge of the rescue operation and Capt. Comella was the hands-on person directing what was going on on site.<sup>62</sup> Mr. Jeffreys testified that he also understood James Cranford to be the in-house engineer for HUSAR/TF3 and that he was prepared to accept his advice and/or opinion. If he disagreed with Mr. Cranford on something, he was prepared to accept Mr. Cranford as being the authority.<sup>63</sup>

Although he did not play a major role in the rescue and only spoke to the members of HUSAR/TF3 on occasion throughout the operation, Mr. Jones testified that his understanding of the command relationship at the site was that there were two different units operating, HUSAR/TF3 and UCRT. He did not know exactly who was in charge and it appeared to him as though the leadership role would change from time to time. As people left the site to attend to other matters, the scene would get handed over to someone else. Mr. Jones indicated that, from his perspective, the various parties appeared to communicate well with each other and seemed to respect each other's abilities and roles. Following the deployment, Mr. Jones and Mr. Lacroix prepared a document showing the time each agency had authority during the operation:<sup>64</sup>

Elliot Lake Fire Department – June 23, 2012 until June 24, 2012 until 0430

Hussar – June 24 at 0430 until June 27, 2012 until 1247hrs

Coroner – June 27, 2012 at 1247hrs until June 29, 2012 at 1611hrs

MOL – June 29, 2012 at 1611 until July 3, 2012 until 1107hrs

Police – July 3, 2012 at 1107hrs until August 1, 2012 at 0800hrs

Ministry of Labour – August 1, 2012 0800 until 12 noon Friday August 3<sup>rd</sup>

Eastwood Mall Inc. – August 3, 2012 at 12 noon<sup>65</sup>

This timeline was prepared on the basis of Mr. Jones's impression at the material time. He testified that he did not dispute that Chief Officer maintained authority throughout the rescue.<sup>66</sup>

Mr. Lacroix testified that, as of the morning of June 25, it appeared to him that HUSAR/TF3 was in charge in charge of the site. Mr. Lacroix had no training on IMS but it appeared to him that Staff Insp. Neadles was the incident commander, which to him meant the person responsible for overseeing the whole site.<sup>67</sup>

## Office of the Fire Marshal's view on chain of command

Ms. Chambers raised a concern during the operation that HUSAR/TF3 was not working in concert with Chief Officer, the incident commander. This concern was set out in an email sent June 24 at 5:50 a.m. in which she gave direction to Messrs. Dave Howse and Robert Thorpe:

Please ensure the IC/FC are engaged with the team. I expect there will be a briefing cycle established. Sometimes HUSAR [TF3] prefers to work alone, but they need to loop back into the IC. They should have provided a radio to the command post, for example, if you could pls verify the link has been made in some regard.<sup>68</sup>

Given that HUSAR/TF3 is not often deployed to a real incident, she wanted to ensure that the lines of communication were well established with the local incident commander. Ms. Chambers explained that she was aware of HUSAR/TF3's tendency not to communicate or work in collaboration with a local fire chief when responding to an emergency. She had observed a similar situation develop during a Trillium joint exercise between UCRT and HUSAR/TF3. She explained that the team is accustomed to working independently and is not really trained to work with the local fire chief. She identified that, while HUSAR/TF3 is very good at its own internal communications, it is equally important for it to be communicating in lay terms to the host municipality in which it is operating in this type of operation.<sup>69</sup>

Ms. Chambers could not recall if she had received confirmation that Chief Officer had been given a radio from HUSAR/TF3. She understood that the two teams' radios were different, an observation during the Trillium training exercise. From her limited understanding, she believed that HUSAR/TF3 had successfully tested an interoperability system but had purchased 40 to 50 extra radios for distribution in the event that it did not work. She did not know whether HUSAR/TF3 had brought the extra radios for the Elliot Lake deployment.<sup>70</sup>

## Staff Insp. Neadles on the chain of command

Staff Insp. Neadles testified that his relationship with Chief Officer during the operation was "fantastic" and, although he knew that Chief Officer was the incident commander, Chief Officer knew that HUSAR/TF3 would work under Staff Insp. Neadles's command as the rescue specialists. He believed Chief Officer felt comfortable that the team would be self-sufficient in its operating skills. He said that he kept Chief Officer updated throughout and believed that the fire chief was prepared to go along with what he (Neadles) felt would be the best course of action.<sup>71</sup> Notwithstanding this statement, the evidence shows that, in reality, Chief Officer was usually informed only after a decision was made and was not provided with an opportunity to give his own input or seek input from others.

Staff Insp. Neadles's understanding of the operational relationship between HUSAR/TF3 and UCRT was similar to that of Sgt. Gillespie. He indicated that he expected that the teams would proceed as they had during their provincial exercises. He expected that UCRT members would have a presence in the command tent and that it would fall under the direction of HUSAR/TF3, but it would not be giving up control of their own people. On a joint deployment, HUSAR/TF3 would retain command and would be able to give orders to a senior member of the UCRT. From his perspective, the UCRT members would be rolled into one of the rescue squads.<sup>72</sup> Staff Insp. Neadles understood that Sgt. Gillespie held the rank of sergeant and that UCRT had not deployed with a staff sergeant. He noted, however, that, even if it had, he believed he would still be able to direct an OPP staff sergeant; in the event of a disagreement, there would be a discussion to attempt to work it out. If they were unable to reach an agreement, he was of the view that he had the authority to pull the UCRT squad from the rubble pile until the disagreement was sorted out.<sup>73</sup> He also believed that UCRT would have arrived in Elliot Lake with the understanding that it would be commanded by HUSAR/TF3.<sup>74</sup>

### OPP UCRT has no presence in the command tent

Ms. Chambers testified that she was not aware during the deployment that UCRT did not have a member in the command tent. She felt that, if Staff Sgt. Jim Bock had been able to deploy, he likely would have been there.<sup>75</sup>

Sgt. Gillespie explained the reason for his absence from the command tent was a question of numbers. He did not have many members with him and no one on the UCRT team ranked at the command level. Because of the low numbers, he had to choose between staying with his team during a shift and being in the command tent. He could not do both. He decided that his duty was to stay with his team in order to ensure its safety. He trusted HUSAR/TF3 and he knew that, based on its low numbers, UCRT would essentially fall in as an extra resource under the direction of HUSAR/TF3. Sgt. Gillespie testified that he would have liked to provide Chief Officer with input but did not think that his not doing so critically affected the way things unfolded in Elliot Lake.<sup>76</sup>

Sgt. Gillespie further testified that, from his perspective and understanding, the incident commander was Chief Officer but Staff Insp. Neadles was interposed as "Strategic Operations Commander." Sgt. Gillespie testified that he was not consulted on this approach. Throughout the deployment, he was never asked by Staff Insp. Neadles for his input about what ought to be done.<sup>77</sup>

### There is a lack of clarity in the roles fulfilled by various persons

Sgt. Gillespie testified that, when he returned to the site at 4:30 p.m., UCRT took on the role of operations leader along with the Elliot Lake firefighters. He had initially believed that Capt. Comella was the operations leader for HUSAR/TF3. However, on his return to the site on the afternoon of June 24, he was advised that Cmdr. McCallion would be acting as the alternate for Staff Insp. Neadles, the overall incident commander for HUSAR/TF3. Sgt. Gillespie understood Staff Insp. Neadles was also the operations section chief and that he was reporting to Chief Officer. Cmdr. McCallion was to be the evening site commander, reporting to Staff Insp. Neadles. Sgt. Gillespie testified that he did not know what Capt. Comella's official role was, but he saw him as a very experienced member of the team and indicated that the two of them worked closely together overseeing the operations within the actual hot zone, the area of the collapse. He testified that he would have expected Capt. Comella to be reporting to either Cmdr. McCallion or Staff Insp. Neadles.<sup>78</sup> He stated that he was in charge of the UCRT resources within the team structure.<sup>79</sup>

Added to Chief Officer's poor understanding of his role and authority, UCRT's failure to place someone in the command tent deprived him of knowledge of the occasional divergence of opinion between the two teams. Different decisions might have been made with the benefit of both views.

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Also at issue was the fact that some HUSAR/TF3 members were fulfilling roles in Elliot Lake that they normally did not perform. Cmdr. McCallion testified that his usual role in a deployment with HUSAR/TF3 would be as medical manager; before Elliot Lake he had not been part of the command team. He became aware of his additional role when Staff Insp. Neadles left the site for the first time to meet with the community control group.<sup>80</sup>



## HUSAR/TF3 is taken on a tour of the Mall with Mr. Jeffreys and Sgt. Gillespie

Mr. Jeffreys testified that he met with HUSAR/TF3 members shortly after their arrival on the scene; he was introduced to Capt. Comella and possibly also to Staff Insp. Neadles. He testified that he explained that he was there to provide whatever assistance he could. Following the introductions, he, Sgt. Gillespie, Capt. Comella, and Mr. Cranford repeated the same tour of the collapse area that had been done earlier.<sup>81</sup>

During this tour, the following hazards and areas of concern were identified.

- Widow-makers and electrical wiring were hanging down from above.
- The hanging beam that was pointing down into the collapse area was swinging in the wind.
- This movement caused the beam to which it was still attached to bend and deflect.<sup>82</sup>
- The concrete slabs on the escalator constituted a hazard; they were quite large and Mr. Jeffreys, Sgt. Gillespie, Capt. Comella, and Mr. Cranford could not understand why they had not slid off the escalator in view of their sharp downward angle.<sup>83</sup>

As the HUSAR/TF3 team members continued the walkthrough of the Mall with Mr. Jeffreys and Sgt. Gillespie, the discussion centred on how to safely approach the pile. It was an open discussion to try to understand the available options.<sup>84</sup> Mr. Cranford believed that the failed beam hanging down into the collapse zone could be removed without affecting the remaining structure. He knew that a crane had been ordered but he did not recall discussing the procedure to be followed to remove the beam. He testified that, once the crane crew arrived, they would be responsible for developing a plan to remove the beam and that he and Capt. Comella agreed that a crane would be the only way to remove it safely.<sup>85</sup>

Mr. Cranford also noted that the beam to which one end of the failed beam was still connected had been badly damaged in the collapse and advised Capt. Comella and Mr. Jeffreys accordingly. The beam was rotated, and given the extent of the rotation, it was unlikely that it was still able to carry its design load. The rotated beam ran along the edge of the collapse zone and was providing support for the hollow core slabs of the rooftop parking deck, to the north of the collapse zone. There was a second beam identified that was also rotated. It was connected to one end of the beam supporting the second floor of the Mall, which had collapsed from the weight of the rooftop slabs and the sport utility vehicle (SUV) that had fallen into the collapse zone.<sup>86</sup>

## Mr. Jeffreys views Mr. Cranford as the principal engineer for the response

Mr. Jeffreys testified that his role differed from that of Mr. Cranford in that he would not be performing any calculations, and Mr. Cranford would be in charge of designing the shoring. However, they were both there to provide advice.<sup>87</sup> Mr. Jeffreys explained their respective roles as follows:

Doing calculations. Doing design work. I can give – well, there is a difference. Design engineers sit in an office or out in the field, in Mr. Cranford's case, and they actually design a structure. And that was entirely his ballpark. He was going to do that. From my perspective, my experience is examining structures that are either collapsed or in the process of collapsing – and I've looked at hundreds of them – and giving advice from that perspective. I was talking about stability of the building, and if Tony [Comella] wanted advice on that, I would give it to him. If he would've asked me to do calculations, I would've declined.<sup>88</sup>

Mr. Jeffreys believed that Capt. Comella understood the distinction between the two roles because he was never asked to do the things that Mr. Cranford was asked to perform. However, he admitted he had never explained this distinction to Capt. Comella.<sup>89</sup>

Mr. Jeffreys testified that he never provided any advice to Staff Insp. Needles. However, he did provide advice to the UCRT members and to Sgt. Gillespie in particular during the initial walkthrough in relation to the beam beneath the escalator and the fact that steel would be needed to shore that beam.

After the walkthrough had been completed and the plan established, Mr. Cranford retired to a room at the Hampton Inn for some rest. At 11 a.m., after only one hour of sleep, Mr. Cranford was asked to return to the site to review the placement of the laced-post shores on the north side.<sup>90</sup>

### **The plan to shore the beam under the escalator is discussed with Capt. Comella**

Capt. Comella and Sgt. Gillespie had worked together previously and had enjoyed a good working relationship. Shortly after his arrival in Elliot Lake, Capt. Comella was provided with the information gathered by UCRT during its reconnaissance, including the plan which Sgt. Gillespie and Mr. Jeffreys had established for the installation of shoring under the beam supporting the escalator. As Sgt. Gillespie explained it to Capt. Comella, the plan involved removing drywall and debris along the pedestrian walkways on either side of the escalator and installing laced-post shores and steel jack posts.<sup>91</sup>

Mr. Jeffreys testified that, after they were told of the plan to shore under the beam, both Mr. Cranford and Capt. Comella decided it would be inappropriate to proceed with shoring in that area.<sup>92</sup> Mr. Cranford testified that, in order to support the bowed beam under the escalator, the shoring would have to be installed directly beneath the beam and sitting on the floor of the lower level of the Mall. The area directly under the beam, as depicted in the photographs taken during the deployment,<sup>93</sup> clearly showed the debris that would need to be removed mostly by hand (some would have taken more work) before any shoring could be put into place directly on the floor. Mr. Cranford indicated that shoring would need to be installed at both ends of the beam supporting the collapsed concrete slabs.<sup>94</sup> Although the beam did not appear to be moving, this would be a difficult and hazardous process.

Although Capt. Comella appeared to have completely discounted shoring under the escalator as an option, Mr. Cranford did not seem to be as definite in his views. As discussed later in this chapter, the option of shoring under the beam was again considered by Mr. Cranford and others later on.

### **Sgt. Gillespie and Capt. Comella discuss a plan for creating a safe access to the rubble pile**

In addition to the abandoned plan to shore beneath the beam supporting the escalator, Sgt. Gillespie and Capt. Comella also formed a plan for entry into the collapse area. It was decided that entry would be made through the Hotel lobby. Significant rubble would need to be removed and laced-post box shores built and placed to support the slabs overhead and pneumatic shores to support the beams.<sup>95</sup> Sgt. Gillespie testified that this discussion and the development of a plan of attack with Capt. Comella was not UCRT making decisions, but rather recommending what should be put in place. The ideas developed by Sgt. Gillespie and Capt. Comella would then have to be presented to a higher level of command for approval.<sup>96</sup>

Entry into the Mall from the north through the Hotel lobby was chosen because it provided access to the pile while providing the safest physical entry at ground level into the collapsed area. Before the pile could be accessed, it was necessary to build a safe zone for the workers to retreat to in the event of a secondary or subsequent collapse. The construction of laced-post shores would provide a safe zone and allow for the hand removal of debris to facilitate access to the collapse area.<sup>97</sup>

Capt. Comella testified that the north entrance through the Hotel appeared to be the least affected area, because it was somewhat removed from the collapse and was part of a larger structure, the Hotel. The Hotel was identified as the safest entrance and the plan was to start shoring and moving toward the pile from the north. The purpose of building and installing shoring was to provide support for the building and an early-warning system in the event of an impending secondary collapse. Capt. Comella told the Commission that the shoring would be made of wood, a material that will bend and twist under the pressure before it fails, providing a warning to the rescuers before it buckles and breaks.<sup>98</sup>

Following the discussions with Capt. Comella regarding the plan for the operation, Sgt. Gillespie stood down the members of the UCRT for a rest. Sgt. Gillespie testified that, when he left the scene, it was with the understanding that HUSAR/TF3 would be shoring the Hotel lobby.<sup>99</sup>

### **HUSAR/TF3 is preparing to start its work**

While Capt. Comella was being briefed by Sgt. Gillespie, the remainder of the HUSAR/TF3 team grabbed a quick meal and by 5:50 a.m. was standing by to receive instructions. The team was briefed by Staff Insp. Neadles and divided into two squads; one would be the day shift and the other the night shift. Capt. Chuck Guy was identified as the leader for the day shift and Capt. Chris Rowland as the squad leader for the night shift.<sup>100</sup> In addition to identifying the squad leaders, the role of search managers was assigned to Sgt. Jim Lawson and Sgt. Dave Zammitt for one team and Sgt. Phil Glavin and Sgt. Avelino Carvalho for the other.<sup>101</sup>

Capt. McRae testified there were a number of meetings in the first hour following the arrival of HUSAR/TF3. He understood his role would be logistics section chief for the operation. His first task was to look at the site and identify a suitable location for the staging area for all the tractors and vehicles. Capt. McRae was in charge of operations if Capt. Comella was unavailable. The few occasions when he was in charge were brief and he simply followed Capt. Comella's direction. He never held the role of planning chief and confirmed that the role was not assigned to one specific person. The planning aspect of the operation was determined by group decision and he, as the logistic chief, was responsible for advising those in the planning group of whether their plan was feasible, taking into account available equipment. Although decisions were made by consensus, Capt. McRae testified that Capt. Comella spent most of his time planning and providing his ideas to Staff Insp. Neadles, who had the final say on plan implementation. From Capt. McRae's perspective, Capt. Comella was the person responsible for developing the plan.<sup>102</sup>

### **Another walkthrough is performed by HUSAR/TF3**

Another walkthrough of the Mall took place, this time with Capt. Guy, Mr. Cranford, and Capt. Comella. The record of this walkthrough was found in Capt. Guy's notes which gave it as occurring at 9:15 a.m. He indicated, however, that the time given in this entry was likely incorrect as he believed it had occurred earlier.<sup>103</sup> The purpose of this additional walkthrough was to remove drywall in areas identified by Mr. Cranford to allow him to have a better look at various areas of the structure and to examine the beams to ensure that the crew would not be working in unsafe areas.<sup>104</sup>

Once the walkthrough was completed, Capt. Guy, Capt. Comella, and Mr. Cranford discussed the quantity, type, and location of the laced-post shores to be constructed and installed in the Mall. Planning could only be done on an evolving basis and was subject to continuous reassessment. It would not be known what would be required until they got to certain areas. The initial task assigned to Capt. Guy and his team was to construct a double-laced-post shore in the area immediately in front of the reception desk of the Hotel lobby and to complete extensive shoring operations throughout the building.<sup>105</sup>



### Although Capt. Comella had dismissed the plan to shore under the escalator, Cst. Waddick believed it was still part of the plan

Although Capt. Comella testified that soon after his arrival on the scene the group made up of Mr. Jeffreys, Mr. Cranford, and Sgt. Gillespie had decided to forgo the option of shoring under the beam, this message did not appear to have been relayed to Cst. Waddick. He testified that, from his perspective, UCRT never abandoned the idea of shoring underneath the escalator and this remained part of his plan when he arrived to start his operational cycle on June 24 at 5:30 p.m.<sup>106</sup>

Mr. Jeffreys's notes made during the emergency response echoed Capt. Comella's evidence that the area under the escalator was deemed unsafe and access would be restricted:

The steel beam overhead, supporting the escalator and stairs at the second floor level, appeared to be sagging under the weight of the concrete that had fallen onto the escalator and stairway from the roof above. The area was deemed unsafe and was restricted pending the possible installation of some heavy shoring.<sup>107</sup>

Although Mr. Jeffreys testified that the shoring under the escalator had been abandoned as an option, his notes record the possible installation of heavy shoring which one could reasonably interpret as being a reference to steel shoring, as had originally been discussed and planned with Sgt. Gillespie. Mr. Jeffreys further explained that he was not the one who deemed the area unsafe; the decision would have been made by Capt. Comella, although he and Mr. Cranford would have discussed the bowed beam with him.<sup>108</sup>

UCRT appeared to have a different perspective of the operational plan. Cst. Waddick testified that, when he ended his shift at 9 a.m., it was his understanding that they were waiting for the crane to arrive and, once it did, the hanging beam would be removed and the crane would be used to remove the debris and the SUV that had fallen onto the pile.<sup>109</sup>

### A "first" incident action plan is developed

Capt. Comella testified that his plan was to go in and support the parts of the structure that were already affected by the collapse on the north side and start working toward the pile from that point. The first step would be to construct the shores in the Hotel lobby to make the area safer and to give the work crew a place to get in and out of the building with equipment and debris.<sup>110</sup> Capt. Comella explained that working toward the pile meant starting "to systematically control movement of every piece and to remove pieces and/or tunnel under pieces to get the victims."<sup>111</sup> Capt. Comella was asked to explain what he meant by the use of the words tunnel and tunnelling, terms used repeatedly by the rescuers. He provided the following details and explanation:

Well, tunneling is a potential, but what we want to do is systematically remove debris in that pile, aiming right at where we understand people might be. So we want to – the closest fastest approach to that pile. And with our equipment, we have choices. We can lift things out of the way. We can lift things up and go underneath them. We can cut them and remove them. We have some options. Those are the Plan A, Plan B, Plan C, to actually do that work, but the objective is to work safely through the pile to get to victims. So we need to stabilize – the pile that you see in this picture is unstable. It potentially is unstable. It's like a house of cards. If you take the right card out, you can cause a secondary collapse, so for us to help anybody, we need to stabilize that scene and make sure that nothing can move. And the intention of moving in towards the pile in a controlled method, using controlled methods, is to stabilize those large pieces of concrete, and to ensure that they don't move, as our rescuers start to move into it, so we take away the potential for dynamic movement, if you will.<sup>112</sup>

Capt. Comella testified that Mr. Jeffreys, Mr. Cranford, and Sgt. Gillespie all agreed with the plan.<sup>113</sup>

He said that using a crane to remove debris would be a last resort. The preferred method would be to shore as they went along and proceed systematically through the pile.<sup>114</sup> This contradicted Cst. Waddick’s evidence that when he left the site that morning the crane was part of the plan.

After the plan was established as described by Capt. Comella, Messrs. Jeffreys and Cranford were asked to look at the drawings and identify the area with the most stable beams. The Hotel area was confirmed as the least affected and therefore the most stable area of the building.<sup>115</sup>

Mr. Jeffreys testified that, although he was involved in reviewing the plan with Capt. Comella and Mr. Cranford, he was not asked if he agreed. He was certain that Capt. Comella and Mr. Cranford understood that his role was not to approve or reject the plan and in fact his approval was never sought the entire time he was at the site. He acknowledged that, if he had noted something glaringly wrong with the plan, he would have raised it.<sup>116</sup>

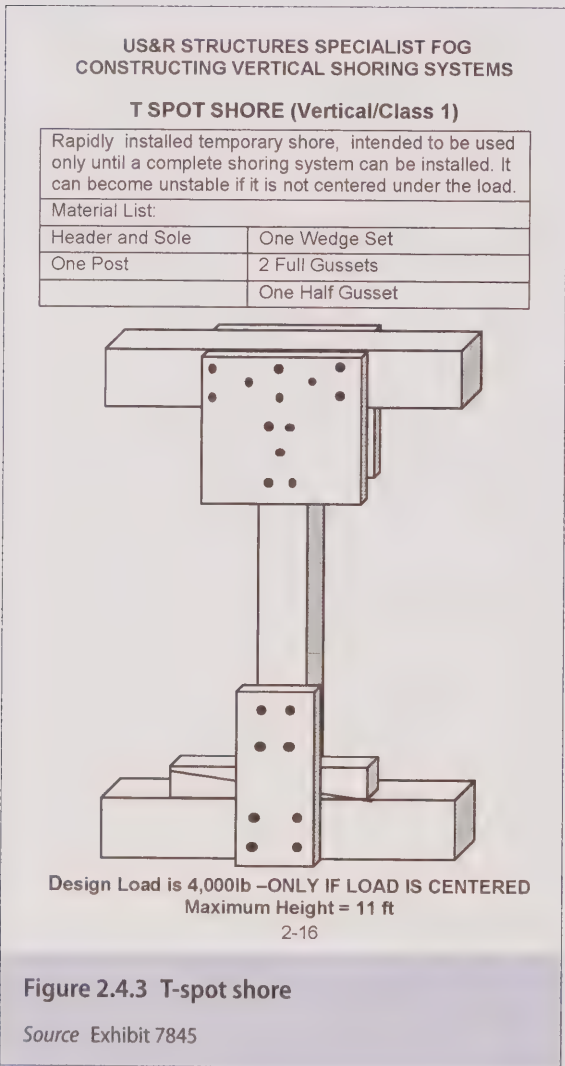
The plan included the decision to install two laced-post shores in the area of the Hotel lobby, right under the edge of the collapse zone, but still in the Hotel lobby area. Because it would take some time to build

the laced-post shores, it was decided to put in two simpler T-shaped shores (T-spot shores, see fig. 2.4.3) as temporary measures to make it safer for the workers while they were building the laced-post shores.<sup>117</sup>

Chief Officer testified that he was made aware of the plan to start with shoring in order to produce a safe work area. He did not recall whether he was informed of what the next steps would be, but believed that the discussion centred on removing the hanging beam. He was disappointed to learn that the shoring would take approximately 12 hours to complete because it made him realize how long and slow the process was going to be. He had a discussion regarding the next steps and was told that they would be removing debris and equipment would be ordered to assist in that process. He did not know whether the crane was part of the plan at that stage.<sup>118</sup>

It was estimated that it would take approximately 12 hours to shore the Hotel lobby and remove debris from that area. There was no expectation that they would get closer to the victims in the first work cycle of 12 hours.<sup>119</sup>

The initial action plan was rudimentary at best. It dealt solely with the initial work to be done and did not extend beyond the shoring.



It had already been recognized at that point that the hanging beam needed to be removed and that a crane would be required to complete that work. While I am reluctant to be critical of Capt. Comella's refusal to consider use of the crane as part of the plan for removing the debris, I have difficulty resisting the notion that his approach was too rigid. Understanding his mindset on that issue eludes me.

### **The incident action plan is not reduced to writing**

Capt. Comella testified that once the plan was discussed, he presented it to HUSAR/TF3's site commander. Capt. Comella confirmed that it was never reduced to writing, except for the rudimentary drawing that had been prepared of the north interior of the Hotel lobby, identifying the locations where the laced-post shores would be installed. When the desirability of a written incident action plan was put to him, Capt. Comella replied: "An incident action plan, certainly at this level, doesn't have to be written down formally, at all."<sup>120</sup> He testified that from his perspective, the drawing was the written incident action plan, but also conceded that the drawing did not identify what would be done beyond the shoring. He explained that, once they had enough debris removed to allow them to walk through, they would re-evaluate to determine the next step.<sup>121</sup>

Although Capt. Comella spoke of debris removal, he did not seem to adequately turn his mind to how these large pieces of concrete slab would actually be moved or removed. He spoke vaguely, in my view, about lifting and shoring them, without elaborating. It was never addressed in his planning.

Capt. Comella testified that he did not have the luxury of time to put his plan in writing but suggested that it could be "formalized" after the plan was passed up to the command post.<sup>122</sup>

Cmdr. McCallion echoed the evidence given by Capt. Comella and testified that under the IMS, incident action plans can be in writing or oral. He testified that he did not believe there ever was a written version of the incident action plan. He acknowledged that, while the team maintained a whiteboard<sup>123</sup> describing the tasks to be completed, it did not outline the plan.<sup>124</sup>

With the benefit of hindsight, Cmdr. McCallion confirmed that it would have been prudent on their part to document the plan in writing. He did not believe that there was a conscious decision not to write the plan down, but rather that they all understood their tasks and roles and proceeded on that basis. Cmdr. McCallion agreed that, without a written plan, someone involved in the operation would not be able to go to a specific location to see the plan and also acknowledged that Chief Officer would be required to ask someone about it in order to obtain any details. As site commander, Cmdr. McCallion did not believe it was his responsibility to keep a written incident action plan.<sup>125</sup>

All the information constituting the initial plan was communicated to Staff Insp. Neadles. Capt. Comella advised him of the hazards identified during the walkthrough and that the plan was to stay away from the escalator and stairs because the debris underneath and the overhead hazard created by the escalator made it impractical to shore that area. Capt. Comella testified that he showed Staff Insp. Neadles the plan of entry from the north and that the rescuers would work from there toward the pile. He further confirmed that this plan was loosely identified as the incident action plan and was approved by Staff Insp. Neadles. He confirmed that Chief Officer was not present when approval to proceed was given. He acknowledged that this meant Chief Officer had provided no input into the plan and that his approval had not been sought.<sup>126</sup>

None of the witnesses assumed responsibility for putting the plan in writing. None identified whose responsibility it was. Clearly, the failure to reduce the plan to writing was contrary to recommended practice and contributed to a less-than-ideal coordination and an unfocused response.



## **Chief Officer is not consulted on and is not asked to approve the incident action plan**

Unprompted by any question from Commission counsel, Capt. Comella attempted to justify or explain the failure to obtain Chief Officer's approval of the plan:

Yeah, and to the point of the Fire Chief not being there when he – when Bill Neadles gave me the go ahead to do this, I think we need to keep in mind that activating this plan takes a lot of time. There's still logistics that have to be done. There is a great opportunity for Bill Neadles to talk to the Incident Commander and verify that this is all fine, to go ahead and do. So I don't know that that piece wasn't done. I assume that that piece was done. There was probably a conversation about that. They certainly have – they have the time to do that long before we ever actually enter the building.<sup>127</sup>

Staff Insp. Neadles recognized that Chief Officer was the incident commander and should have been the one to approve the plan. He acknowledged that he did not consult Chief Officer before approving it. In an effort to explain his actions, he testified that he was under the impression that Chief Officer had authorized him to move forward on the plan, without the need to consult him first, because he (Officer) had told him to do what needed to be done.<sup>128</sup>

## **6:00 a.m.: There is no plan beyond shoring the Hotel lobby**

It was acknowledged by Cmdr. McCallion that, once the shoring was completed to the point where the team would be able to access the pile, the next step would likely be to continue with the search, through the use of canines, search cameras, and acoustic equipment to better determine the location of the victim. However, these next steps had not been discussed or formalized with the team. As of 6:00 a.m. the plan was simply to enter the north side of the building and clear debris and install laced-post shores in the Hotel lobby.<sup>129</sup>

Staff Insp. Neadles testified that the incident action plan prepared by Capt. Comella only covered the first operational period. They would not be able to go any further into the building or make a further assessment until they got through the Hotel lobby area and into the main building. Although they had an idea of where the victims were located and were moving in that direction, they had not at that point formulated a plan specifying what would occur once they got into the building.<sup>130</sup>

## **The first operational shift begins shoring in the Hotel lobby**

The first operational shift was scheduled to begin at approximately 6 a.m.; the operational team for this shift was made up solely of HUSAR/TF3 members. UCRT members had gone to bed at that point and would only return to the site at 6 p.m. to start the second shift, which would also include HUSAR/TF3 members. During the morning/day shift, there was no UCRT presence in the command structure or the command tent and this situation did not change when Sgt. Gillespie returned for the second shift. Cmdr. McCallion testified that he would have expected a member of the UCRT in the command tent but could not explain Sgt. Gillespie's absence.<sup>131</sup>

As of 8:20 a.m., the first shift of HUSAR/TF3 rescuers was preparing to commence the first of its assigned tasks: building shores and clearing out debris to allow the rescuers to gain access to the collapse zone.<sup>132</sup> Capt. Guy testified that there was significant structural damage and debris that needed to be removed. He testified that, by the end of their shift, they had completed 99 percent of the double-laced posts and built a 6-by-6 solid sole raker against one column. The Elliot Lake Fire Department assisted the day shift with the construction and assembly of the shores outside the Mall.<sup>133</sup>

### Sgt. Phil Glavin starts working on a possible Plan B

While those in command were discussing and developing the first incident action plan, Sgt. Phil Glavin, a member of HUSAR/TF3 and a search manager, started to think about a possible “Plan B,” and during the morning of June 24 he contacted Priestly Demolition. He testified that he was aware of the type of equipment owned by the company, which included a large crane with an articulated arm that allows it to reach out and down. He explained that this equipment had the ability to grab and crush, as well as perform more intricate manoeuvres such as turning, reaching, cutting, and gently piling materials. He thought this equipment might be of assistance during the operation. He explained that he was familiar with the operations of Priestly Demolition because he is related to the owners through marriage and his father and brother worked for the company. He contacted his brother to find out whether the equipment was available to be sent to Elliot Lake to assist with the rescue. He testified that he had not discussed making this call with anyone else within HUSAR/TF3 and did not relay any of the information he received until later in the response.<sup>134</sup>

**Sgt. Glavin explained that this equipment had the ability to grab and crush, as well as perform more intricate manoeuvres such as turning, reaching, cutting, and gently piling materials. He thought this equipment might be of assistance during the operation.**

Ryan Priestly, owner of Priestly Demolition, confirmed that he received a telephone call from HUSAR/TF3 on June 24, although his notes do not specify the time of the call. Although Sgt. Glavin testified that he had spoken to his brother on June 24, Mr. Priestly testified that he was the one who spoke with Sgt. Glavin and was asked whether he was available to go to Elliot Lake to assist with the collapse and was also asked about the high-reach machine. Mr. Priestly confirmed to Sgt. Glavin that his machine was available. Mr. Priestly testified that after his discussion with Sgt. Glavin he was on unofficial standby.<sup>135</sup>

### 8 a.m.: Community Control Group (CCG) meetings

A CCG meeting was held on June 24 at 8 a.m. In attendance were Chief Officer; Kate Matuszewski, the information officer for the City of Elliot Lake; Darla Hennessey, the person in the group responsible for social services; Bruce Ewald, chief building official, City of Elliot Lake; Henry Allamanchuk, the head of Emergency Management Services; Dan Newburn, a representative of the Office of the Fire Marshall sent by Ms. Chambers; Natalie Bray, administrative assistant to the CAO of the City of Elliot Lake; Jocelyn Labreche, a City of Elliot Lake employee; Insp. Percy Jollymore of the East Algoma Region OPP; Bonnie deBortoli, the scribe for Insp. Jollymore; Robert deBortoli, chief administrative officer of the City of Elliot Lake; Natalie Quinn, scribe for Chief Officer; Mayor Richard Hamilton; and four City councillors (Tom Farquhar, Sandy Finamore, Norm Mann, and Al Collett).<sup>136</sup> During the meeting, the group was brought up to date and advised that HUSAR/TF3 needed to confirm the number of missing people. The OPP was asked to try to narrow down the number of missing.<sup>137</sup> The attendees were also notified of the following:

- The beam by the Hotel would need to be secured before they could move forward. It was estimated this work would take 12 hours to complete.
- A finance person was required on scene because the rescuers were ordering a lot of items and someone was needed to deal with procurement. Chief Officer confirmed that Don Halcro, the City treasurer, was sent to fulfill that role and was in the command post with Chief Officer from time to time during the operation.
- Skid steers with forks and mini-excavators with claws were required for the site.
- There had been confusion on the ordering of a crane.<sup>138</sup>

Chief Officer testified that at the meeting it was confirmed that HUSAR/TF3 had not ordered a crane but that it had been ordered by the OPP, at the request of Cst. Cox. Chief Officer testified that he did not believe that the confusion surrounding the crane had to do with the differing opinions about whether the crane was necessary. From his perspective, he did not see how they could move forward without a crane, as there was no other way to remove the hanging beam. He further explained that the confusion discussed at the meeting related to the capabilities of the crane that had been ordered and whether it would be able to meet their needs. Although the CCG meeting notes indicated that the crane was onsite at the time of the meeting, Chief Officer indicated that this was incorrect.<sup>139</sup> The evidence showed that the crane did not arrive in Elliot Lake until approximately 11:15 a.m., several hours after this meeting.

During the meeting it was also noted that gaps were developing in the communications with the media and that a better communication strategy was required to control information being disseminated in the community. The two press conferences held subsequently were part of the effort to close that gap.<sup>140</sup>

Insp. Jollymore testified that, on the issue of the media and information sharing, there was debate over how much to reveal to the public about the victims. It was decided to hold a panel-style press conference, and he

was given the task of dealing with the list of people who were missing and possibly trapped in the Mall. At that point, five people were still listed as missing. Insp. Jollymore explained that the City wanted to have a consistent message from the group on the status of the rescue.<sup>141</sup>

**Insp. Jollymore testified that, on the issue of the media and information sharing, there was debate over how much to reveal to the public about the victims.**

Staff Insp. Needles testified that he was not present at the 8 a.m. CCG meeting.<sup>142</sup> He stated that normally HUSAR/TF3 member Division Chief Doug Silver, as the planning officer, would have made contact with the local authorities and would have attended the CCG meeting to speak on behalf of the team.<sup>143</sup> As planning for the Elliot Lake deployment was done “by committee,” no one from HUSAR/TF3 was in attendance, an unsatisfactory result.

## The crane is on its way to Elliot Lake

Capt. Comella testified that when he arrived in Elliot Lake he was not aware that a crane had been ordered. He was informed of this detail later on. However, even when he saw the size of the concrete slabs that had collapsed on the pile, it would not have been a priority for him to order a crane. The use of cranes is not the favoured method employed by HUSAR/TF3 to rescue people entrapped beneath concrete.<sup>144</sup>

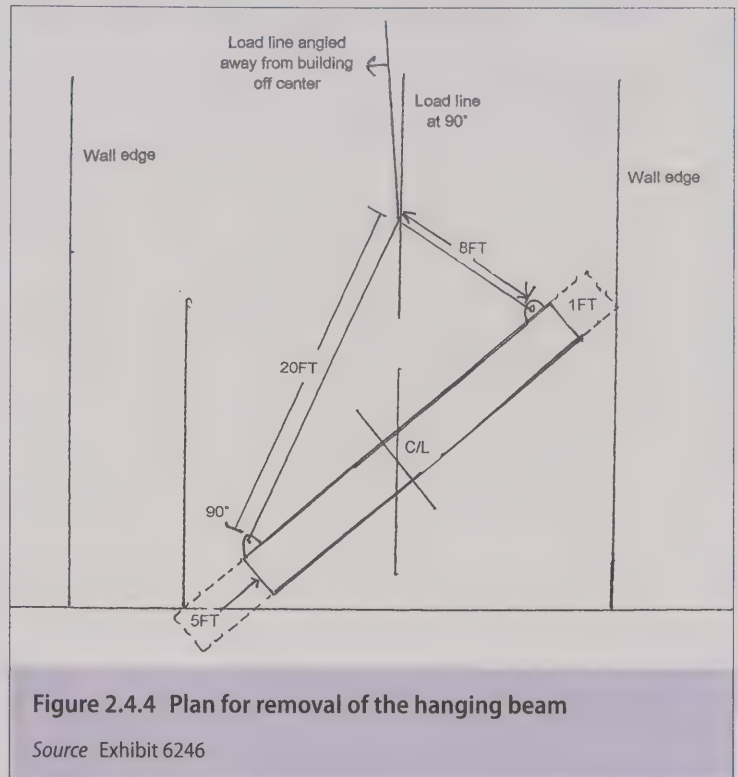
Millennium Crane was ready to mobilize out of Sault Ste. Marie and undertake the trip to Elliot Lake at 6:30 a.m. The company proceeded to Elliot Lake with 10 crew members, including three certified hoisting engineers and one certified ironworker.<sup>145</sup> Millennium initially supplied a 165-tonne crane and a 30-tonne crane. It took three-and-a-half hours to travel from Sault St. Marie via Highway 17 to the exit to Highway 108 to head to Elliot Lake. It was only at the exit that Millennium was met by a police escort. The owner of Millennium Crane, Dave Selvers, testified that he could have arrived in Elliot Lake sooner if he had been provided with a police escort for the entire route.<sup>146</sup>

The 165-tonne crane arrived in Elliot Lake at 11:15 a.m. and was brought directly onto the grounds of the Mall. Once the crane was parked on level ground, Mr. Selvers was met by Chief Officer, as well as members of UCRT, OPP and HUSAR/TF3, the chief building official, and an inspector from the Ministry of Labour.<sup>147</sup> Mr. Selvers testified that at this point he assumed the Ministry of Labour was in charge of the rescue, though he did not ask who was in charge.<sup>148</sup>



In order to assess the situation and the work to be completed, Mr. Selvers proceeded to the second floor of the Mall and looked into the collapsed area. He then continued to the rooftop parking deck, which allowed him to see the hanging beam for the first time. From his perspective, the hanging beam was the first thing that needed to be removed. He also realized that the 30-tonne crane would not be sufficient and immediately ordered a larger crane. He also contacted the police in Sault Ste. Marie to request a police escort to take his crane operator from a Michigan campground to Elliot Lake.<sup>149</sup>

Mr. Selvers testified that someone from the Ministry of Labour asked if he had a plan for the removal of the hanging beam but did not ask to see the plan. He was prepared to show the ministry his plan had they asked for it. The plan he had developed was similar to the diagram included in his after-action report (see fig. 2.4.4).<sup>150</sup> He testified that the inquiries by the Ministry of Labour did not delay the operation to remove the beam.<sup>151</sup>



**Figure 2.4.4 Plan for removal of the hanging beam**

Source Exhibit 6246

Mr. Selvers was asked to respond to the evidence that had been previously given by Capt. Comella in which he described the rigging training given to the HUSAR/TF3 members as:

They put a crane in front of you for either a half or three-quarters of a day and 14 people stand there and take turns operating a hoisting operation, a floating operation. That's really the training, and a little bit of the academic side, to understand the hazards that can be posed by rigging, et cetera.<sup>152</sup>

He stated that, from his experience operating a crane, the training received by HUSAR/TF3 as described in the evidence of Capt. Comella was inadequate to allow someone to assist him in a situation similar to the one in Elliot Lake.<sup>153</sup>

Staff Insp. Neadles testified that the decision to start the crane operations was his; however, he could not recall whom he spoke to in order to authorize the use of the crane.<sup>154</sup> Capt. Comella stated that he was not aware a crane was going to be used or its purpose.<sup>155</sup> Staff Insp. Neadles expressed surprise when it was put to him that Capt. Comella, as the operations chief, had not been aware that the crane was going to be used. He acknowledged that most of the communication on the scene was verbal and that the fact that Capt. Comella was unaware of certain facts relating to the crane was a failure in communication.<sup>156</sup> I agree. The situation was exacerbated by Staff Insp. Neadles's failure to appoint a planning officer.

## 9 a.m.: The City of Elliot Lake issues a press release

At 9 a.m., a press release was issued, stating: “At this time no casualties have been reported or confirmed.”<sup>157</sup> Mayor Hamilton testified that he believed this to be a truthful statement at the time because it pertained to whether there was someone deceased on the pile. He subsequently acknowledged that an emergency medical services person had reported that a person had been located with no pulse, and agreed the statement as released was untrue.<sup>158</sup>

Mr. deBortoli also agreed that the press release indicating that there were no reported or confirmed casualties was inaccurate and conceded that “casualties” would include deceased as well as injured persons.<sup>159</sup> The press release had been reviewed by the OPP, the mayor, the press coordinator, and Mr. deBortoli and subsequently released to the public despite the admitted inaccuracy.<sup>160</sup>

The information provided in the press release was contrary to the update Staff Insp. Neadles had given to Ms. Chambers in an email sent at 8:57 a.m. in which he reported there was one deceased victim.<sup>161</sup> In her testimony, Ms. Chambers justified the discrepancy by stating that, not having all the information, the media spokespersons tend to be highly optimistic that the victims waiting to be rescued are still alive until the contrary is absolutely confirmed. She indicated that they tend to err on the side of caution. Until the information can be verified by a person in authority, the information is not released.<sup>162</sup>

## 9:30 a.m.: The rescuers report a second sign of life, the first since the firefighters had communicated with the victim shortly after the collapse

At approximately 9:30 a.m., search managers Sgt. Jim Lawson and Sgt. Dave Zammit and canine handler Sgt. Scott Fowlds were tasked with carrying out a reconnaissance of the Mall. During their reconnaissance, they heard tapping noise in response to a call-out by Sgt. Lawson. The results of their call-out were reported to command.<sup>163</sup>

The reported signs of life influenced the decisions made by the rescuers in the steps taken to try to reach the victims.

The evidence of the different instances where signs of life were reported on June 24 and June 25 is recounted in this chapter in order to provide a coherent narrative and an accurate and complete chronology of the events which took place during the rescue efforts. The reported signs of life influenced the decisions made by the rescuers in the steps taken to try to reach the victims. More comprehensive details of all of the signs of life are described in Chapter 8, The Victims: Cause and Time of Death.

## 11:00 a.m.: Staff Insp. Neadles sends an update – the work is under way

At 11:00 a.m. on June 24, Staff Insp. Neadles issued another update to Ms. Chambers and others with the City of Toronto:

- The team had started working in the building starting from the Hotel entrance.
- The wood-cutting table had been constructed and was in use.
- The canine team had been sent in to search the Mall.
- Contact was established with the victim at 9:30 a.m., and it was believed this was the same victim as the previous night. The contact was established through tapping; it was short-lived but nevertheless confirmed that the victim was still alive.

- It was going to take a substantial period of time to reach the victim.
- The Community Control Group had met with the media.<sup>164</sup>

Staff Insp. Neadles testified that, at the time he provided this update, he had not been advised of the results from the canine search.<sup>165</sup>

## Premier Dalton McGuinty reaches out to Mayor Hamilton

Premier McGuinty got in touch with Mayor Hamilton on Sunday, June 24, and spoke to him by telephone at 11:30 a.m. Premier McGuinty testified that the purpose of his call was to let the mayor know that he had his support and the support of the provincial government. He also wanted to hear from Mayor Hamilton about the challenges he was facing and to convey to him that he should not hesitate to ask for provincial resources if something in particular was needed. During the call, Mayor Hamilton did not request anything other than to express his concern about the members of the community who might be trapped in the rubble.<sup>166</sup>

Following the premier's discussion with Mayor Hamilton, his office issued a press release:

I want to thank our emergency crews in Elliot Lake as well as those that have come from southern Ontario to help with the rescue effort for their good work around the clock.

I spoke with Mayor Rick Hamilton this morning. As we anxiously wait to learn more about anyone thought to be missing in Elliot Lake, our thoughts and prayers are with their families, and also those who have been injured and indeed with the entire community.

During a crisis like this, I am reminded of the strength and resilience of Northern Ontarians, and how by pulling together with our friends, families and neighbours, we can get through these difficult times.<sup>167</sup>

The purpose of the press release was to convey to Ontarians that the province was engaged and to convey sentiments of reassurance, comfort, and thanks. Mr. McGuinty testified that the reference to his discussion with the mayor was to convey to the people of Elliot Lake and Ontarians that they were in close communication.<sup>168</sup> I discuss Premier McGuinty's involvement in much greater detail later in the Report.

## 12 p.m.: A CCG meeting is held

A further CCG meeting was held at 12 noon. Many of the same attendees from the earlier morning meeting were present.<sup>169</sup> At this time, Chief Officer informed those in attendance that a 165-tonne crane was on its way to Elliot Lake and he confirmed that Capt. Thomas had informed him that tapping had been heard from the rubble pile.<sup>170</sup> The notes from the 12 noon CCG meeting indicated: "Rob/Paul/Percy/Rick to meet again now for press conference."<sup>171</sup> Chief Officer testified that this additional meeting was to prepare for and to decide who would be answering questions during the press conference.<sup>172</sup>

The group was also advised that the coroner, Dr. Marc Bradford, had been contacted and was on call but would not be travelling to Elliot Lake until the situation changed.<sup>173</sup>

**At this time, Chief Officer informed those in attendance that a 165-tonne crane was on its way to Elliot Lake and he confirmed that Capt. Thomas had informed him that tapping had been heard from the rubble pile.**



## 12:10 p.m.: Sgt. Fowlds reports an indication of a live hit by his canine, Ranger

At 12:10 p.m., Ranger, Sgt. Fowlds's dog, was deployed onto the pile. This search resulted in a positive indication of a live person in the rubble pile. Ranger gave a positive indication in the area near the SUV (see fig. 2.4.5).<sup>174</sup> Command was notified of the results of the search.<sup>175</sup>



**Figure 2.4.5** Ranger gave his positive indication in the area near the railing to the left of the SUV

Source Exhibit 7924

## 1 p.m.: Staff Insp. Neadles sends an update – the crane will be used to assist with the removal of large debris

Staff Insp. Neadles provided a third email update to Ms. Chambers and others with the City of Toronto at 1 p.m.:

Operations continue towards reaching the live victim as of 0930 hours. (Sensitive). We are building shoring to support a main column and beam and setting up a large crane to assist with some large debris removal. This is our primary objective at this time.<sup>176</sup>

Staff Insp. Neadles testified that he had marked the email “sensitive” because he did not want the public to be advised that there was a potential live victim under the pile.<sup>177</sup>

In this update, Staff Insp. Neadles made reference to a primary objective, but it is not clear what was being identified as such. He explained that the “primary objective” was the shoring to be completed, which would allow the rescuers to move deeper into the building.<sup>178</sup> A reading of the update could equally be interpreted to mean that the removal of large debris was the primary objective.<sup>179</sup> Capt. Comella had received a copy of the third update but did not know what the “primary objective” was at 1 p.m. He testified that he understood at that time

that the shoring operation working toward the pile was an objective.<sup>180</sup> Staff Insp. Neadles was surprised to learn that Capt. Comella had testified that he did not know what the primary objective was as it was his (Comella's) plan they were working from.<sup>181</sup> Cmdr. McCallion had also received the third update and he believed that the reference to the primary objective made by Staff Insp. Neadles was getting to the victims.<sup>182</sup>

The fact that the three primary commanders of HUSAR/TF3 were not *ad idem* on the information conveyed in this update is a cause for concern and reflects further on the poor communications throughout the response.

## **1 p.m.: The City of Elliot Lake issues another press release – still no information provided on the known status of the victims**

A second press release was issued by the City of Elliot Lake at 1 p.m.:

The City of Elliot Lake and Special Emergency Service teams remain on scene and continue to work on the stabilization of the affected area of the mall. Search and rescue dogs continue to be utilized in this process.

There is no confirmation on any loss of life. This is still a rescue effort.<sup>183</sup>

Chief Officer testified that the statement made in the press release was not true. He indicated that Insp. Jollymore was concerned about releasing a statement that a deceased person had been located because he did not want to make a mistake. He further testified that no one shared Insp. Jollymore's opinion.<sup>184</sup> However, they acquiesced with Insp. Jollymore's instructions because of the OPP's experience dealing with coroners.<sup>185</sup> OPP Chief Supt. Robert Bruce confirmed in testimony that OPP personnel cannot confirm a death and that only the coroner or a doctor can do so, unless there are clear signs of death, such as decapitation or decomposition.<sup>186</sup> The same information was given to the public during the 1 p.m. press conference as had been included in the press release issued at the same time.<sup>187</sup> Chief Officer testified that he did not like misstating the facts to the public but he knew that the group needed to present a united front. He was concerned that the public was looking for information and they were not receiving it. He believed that when the rescuers had the opportunity they should have publicized the correct information.<sup>188</sup>

Mr. deBortoli testified that this latest press release was not misleading because at that point they still had not confirmed that there had been a loss of life and they were still treating the situation as a rescue.<sup>189</sup> He ultimately agreed, upon being pressed further, that the press release could have stated more specifically that one victim was potentially alive and there were indications that the other victim might not be.<sup>190</sup>

## **Further options are explored to stabilize the stairs and escalator**

At 2 p.m., Mr. Cranford and Capt. Comella once again discussed the possibility of stabilizing the escalator and stairs supported by the bowed beam at the south end of the collapse zone.<sup>191</sup> They discussed the possibility of shoring underneath the beam supporting the escalator. However, they were concerned that the hollow core slabs could slide off the escalator at any time, killing or injuring a rescuer and/or causing a secondary collapse of the building. In order to place shoring under the beam, workers would have been required to stand underneath the escalator for several hours to complete the work. This was not seen as a workable solution. They began looking at the possibility of restraining the hollow core slabs from above.<sup>192</sup>

Mr. Cranford testified that, in his discussions with Capt. Comella, they came up with three options for dealing with the escalator and the weight of the hollow core slabs:

- Place tarps over the escalator to prevent water from seeping through and potentially causing the slabs to slide;
- Drill lugs\* into the concrete slabs and run high-tensile steel cables back to the rock anchors which would have to be installed in the ground level parking lot of the Mall. This option was eliminated because the drilling would cause vibrations and would require a rescuer to be placed physically on top of the slabs.
- Wrap the concrete slabs with high-strength straps and tie the entire assembly to a rock anchor in the surface of the ground level parking lot. This option, although strongly considered, was also discarded because it required the rescuers to remove significant pieces of debris hanging from the face of the elevator frame. In order to remove the debris, the rescuers would have needed to cut away rebar and pre-stressing strands, which could have shifted the load and created additional problems.<sup>193</sup>

Mr. Cranford testified that, by the end of the day on June 24, it had been concluded that it was not possible to secure the concrete slabs resting on the escalator. However, he did not discuss any of these options with Staff Insp. Neadles or Cmdr. McCallion.<sup>194</sup>

## The plan changes – but it's still not put into writing, nor is a meeting held to discuss it

According to Cmdr. McCallion, by 3 p.m. the plan was changed to include the removal of the hanging beam, and they also began contemplating the removal of the concrete slabs resting on the escalators. Cmdr. McCallion testified that this new plan involved using the crane to remove the concrete slab from the escalator in order to provide more flexibility for work inside the pile. He indicated that once the shoring was secured on the north side, the work would continue on the pile to remove debris until they got to the victims. This plan to remove the concrete slab was discussed by Mr. Cranford, the Ministry of Labour engineer, and Capt. Comella. Sgt. Gillespie was also part of the team that developed this next plan. Cmdr. McCallion acknowledged that, for the most part, the discussions on planning were not taking place in the command tent and were generally being conducted in the absence of both him and Staff Insp. Neadles. He confirmed that the plan would eventually have been presented to him for approval, if he was in charge at the relevant time, or to Staff Insp. Neadles.<sup>195</sup>

Staff Insp. Neadles testified that as of 6:04 p.m., the plan was to continue shoring in order to eventually remove the beam. As far as he could recall, the removal of the slab off the escalator was still part of the plan. He admitted, however, that he did not discuss the feasibility of removing the concrete slab off the escalator with Mr. Cranford but nevertheless concluded that it was not a viable option. He thought it would be unsafe and too lengthy an operation, requiring materials such as steel that were not available to them.<sup>196</sup>

**The evidence relating to what was included in the incident action plan was disjointed and convoluted ...**

The evidence relating to what was included in the incident action plan was disjointed and convoluted; many of the HUSAR/TF3 members provided differing accounts and interpretations of what was to be done. This confusion and the conflicting answers about the plan would have been eliminated altogether if it had simply been reduced to writing. It would also have been wise to bring everyone together (all the teams) to discuss the plan and other strategies.

• • • • •

\* A connector (such as a steel ring or handle) used to fasten cables to an object in order to lift or support the object.



### 3 p.m.: Staff Insp. Neadles sends an update advising that the concrete slab on the escalator will be removed

At 3 p.m., Staff Insp. Neadles sent his fourth update to Ms. Chambers and others with the City of Toronto, although it was incorrectly titled "Update #5." In his email update he indicated:

Operations continue focused on the locating of the know [sic] victim as contacted this morning. The team continues to build Raker Shores, T spots and Lace Posts from the north end while the large crane is slowly being placed to enter via the roof to have a Steel worker attach eye bolts, secure and the [sic] cut in half and remove. They will also bring in a second crane to assist with this operation. This will allow the next step of removal of a very large slab of concrete lying insecurely on the escalator.<sup>197</sup>

Staff Insp. Neadles explained that the removal of a large piece of concrete slab off the escalators was a possibility being explored. He was trying to provide the best information he could to the recipients of his updates, including what might be done in the next operational period. He explained that nothing was absolute and therefore not everything included in the updates ultimately took place.<sup>198</sup> He testified that he was not trying to mislead the readers but acknowledged that any reasonable person reading this update would have believed that the removal of the concrete slab from the escalator had become part of the plan.<sup>199</sup>

Staff Insp. Neadles did not dispute Capt. Comella's evidence that he was unaware that the removal of the concrete slab was being considered and he could not recall who would have proposed that part of the plan.<sup>200</sup> Mr. Cranford also testified that he was never asked to give advice about removing the concrete slabs sitting on the escalator,<sup>201</sup> and that the whiteboard listing the tasks<sup>202</sup> did not include the removal of the slabs. When faced with this evidence, Staff Insp. Neadles then testified that the removal of the slabs was not necessarily part of the plan, but he believed it was being discussed or it could have been something that only he was considering.<sup>203</sup>

When shown the 3 p.m. update, Mr. Selvers testified that he had been told by an OPP officer about a plan to remove large pieces of concrete off the escalator after the beam was removed but that he was never asked to draw up a plan for that work.<sup>204</sup>

Again, this confusion could have been avoided if a planning person had been designated by Staff Insp. Neadles.

In his update, Staff Insp. Neadles also notified the recipients that the media frenzy was increasing.<sup>205</sup> He attributed it to the fact that the OPP did not want information on the victims to be released. Cmdr. McCallion testified that he did not understand the reluctance to release this information. It made no sense to him.<sup>206</sup>

### The cranes are set up and ready to be used

At 3:45 p.m., the larger crane (60-tonne), ordered by Mr. Selvers shortly after his arrival at the scene, arrived in Elliot Lake.<sup>207</sup> Mr. Selvers testified that he did not believe he had lost any time while he waited for the 60-tonne crane to arrive because there was still procedural planning to be done. The plan was to use the 165-tonne crane to remove the hanging beam and the 60-tonne crane to suspend the workers in a basket inside the collapse area.<sup>208</sup>

Because of the configuration of the Mall and the location of the collapse, the only place they could position the cranes was in front of the interior corner of the Mall, at the entrance doors to Foodland. The 60-tonne crane was positioned to the left of the entrance (or along the long part of the L shape of the Mall).<sup>209</sup> It was equipped with a 110-foot main boom and a 60-foot jib (the flexible part off the main boom) which was offset at 30 degrees. The 165-tonne crane was to the right of the entrance and had a 164-foot main boom and 60 feet of jib. The jib was kept at zero degrees to give it a better lifting capacity as it would be the one to hoist out the hanging beam.<sup>210</sup>



**Figure 2.4.6** The red part of the larger crane is the jib and the boom is white

Source Exhibit 7924

Mr. Selvers testified that one important concern with crane operations is the swing range. He explained that normally he likes to have a swing range of 360 degrees but in the case of the Algo Mall they had to exercise caution because they had only 110 degrees of swing available and the two cranes were working in close proximity. It was not possible to place them farther apart because of the location of the collapse zone in relation to the rest of the building.<sup>211</sup>

Mr. Selvers testified that it was determined that the only way to remove the beam was to rig it by wrapping cables around it, all while ensuring to maintain the angle at which it was hanging. Once the beam was secured with cables, it would be freed using a cutting torch.<sup>212</sup> In order to maintain the angle of the beam, the rigging was offset, with one cable shorter than the other. The boom of the crane was also offset to control the movement of the beam once it had been cut away.<sup>213</sup> The purpose of controlling the movement of the beam, once cut, was to avoid having it come into contact with the walls, the nearby beams, or the stairwell, which had concrete resting on top that could not be disturbed.<sup>214</sup>

He also testified that Chief Officer was concerned about the safety of the workers who would be located in the basket doing the cutting. Mr. Selvers indicated

to Chief Officer that his own son would be in the basket and that he would never put his son in harm's way. This appeared to alleviate some of Chief Officer's concerns. Mr. Selvers indicated that he did not discuss his plan with Staff Insp. Neadles and did not recall discussing it with anyone else from HUSAR/TF3 or the engineer from the Ministry of Labour.<sup>215</sup>

Mr. Cranford testified that he reviewed the strategy for cutting and removing the beam, but he did not provide an opinion. It was beyond his expertise. He believed that it was either Capt. Comella or Mr. Jeffreys who sought his input, and he advised them that he could not advise on the strategy because he did not have much experience with hoisting and cranes.<sup>216</sup>

### 3:57 p.m.: The CCG meets and is advised that the crane is in place

At 3:57 p.m., another CCG meeting was held. On this occasion, Staff Insp. Neadles was present. Those in attendance were advised by Chief Officer that the crane was in place and that the beam extraction would begin upon approval.<sup>217</sup> Chief Officer testified that it was his recollection that his approval was sought; he had concerns with the removal of the beam, in particular the safety of the people who would be involved in the operation. It required that workers be suspended from a basket attached to one crane inside the collapse area in order to cut the beam, while the other crane held the beam.<sup>218</sup>

The notes on the meeting also mention next steps, which included a further meeting between “Rob/Rick/ Paul/Percy”<sup>219</sup> to discuss the 5 p.m. press conference. Chief Officer confirmed that this note was a reference to another meeting that was to take place in advance of the next press conference, similar to the one that had occurred earlier.<sup>220</sup>

Staff Insp. Needles testified that his purpose in attending the 3:57 p.m. Community Control Group meeting was to provide support and supply information as best he could.<sup>221</sup> He advised the group that at 9:30 a.m. there had been a confirmed identification of a victim but no further contact or confirmation since then. The group was also informed that the shoring was continuing from the north heading south in the direction of what was believed to be the location of the victim.

At that time, the CCG was informed that the plan was to remove the beam first and then the concrete slab on the escalator. Staff Insp. Needles testified that he believed the group was advised the operation would take 12 hours to complete. He said that, when he advised the group that the concrete on the escalator was going to be removed, he had not reviewed the photographs. Once he viewed the photographs of the concrete on the escalator, he knew that they would not be able to remove the slabs. He agreed that he should not have communicated a plan that could potentially not be achieved.<sup>222</sup>

### **4:40 p.m.: The City of Elliot Lake issues a press release – the public is advised of a casualty**

At 4:40 p.m., a press release, prepared jointly by the media representatives for the OPP, Elliot Lake Cst. Christine Ouimet and Kate Matuszewski,<sup>223</sup> was issued to the public and contained the following statement:

The Emergency Management Team is providing the following information:

Examination of the scene continues to indicate that this is still a rescue. Evidence has been uncovered that leads us to suspect that there may be a casualty.<sup>224</sup>

### **OPP UCRT returns to the site to begin the night shift**

At 4:30 p.m., Sgt. Gillespie returned to the site following his rest period. He was informed that the next briefing would be at 6 p.m. and was told by Cmdr. McCallion that shores were being built in the area of the Hotel lobby at the north end of the collapse. At this time, Sgt. Gillespie and Cmdr. McCallion exchanged radios so that they could be kept apprised of what was happening with the other team. Despite the exchange, the radios were used infrequently during the deployment.<sup>225</sup> Sgt. Gillespie arrived before the rest of his team, who were scheduled to return to the site for 6 p.m., so he could ascertain the night shift tasks and brief his team when it arrived. He expected there would be a meeting of the commands and the squad leaders at 6 p.m. to bring everyone up to speed on the tasks that needing completion. This did not happen. Sgt. Gillespie was unable to explain why this meeting did not take place.<sup>226</sup> The failure to hold this meeting was contrary to Sgt. Gillespie’s training and to the predecessor of a UCRT document entitled, “Standard Operating Procedures Relating to Urban Search and Rescue Incident Response,” dated August 2012.<sup>227</sup> This document provides that:

- USAR operations require the close coordination of all team elements for safe and successful victim extrications.
- The central point of coordination of the team lies with the team leader.



- The team leader is charged with the overall responsibility of the personnel, resources, equipment, and operations from the point of activation to demobilization at the home jurisdiction.
- This position, in conjunction with the team's supervisory personnel, must mould the various elements of the team into an integrated unit, during mission assignment.
- The team leader is responsible for the control of the team at all times.
- The team leader will ensure that an effective team command structure exists and is maintained throughout the course of the mission.
- The team leader may receive direction from the incident commander and is responsible for implementing strategic and tactical assignments.<sup>228</sup>

A previous standard operating procedure, essentially identical, was in effect in June 2012.<sup>229</sup>

Cst. Waddick returned to the site at 5 p.m. He was briefed by Sgt. Gillespie at 5:30 p.m. and the UCRT team was divided into two squads, one led by Cst. Chris Collins and the other by Cst. Hulsman. Cst. Waddick was assigned to Cst. Collins's squad, which was tasked with continuing shoring into the north building near the entrance to the Hotel lobby and the loading dock. He further testified that he had been informed that the decision had been made to remove the hanging beam, followed by the SUV, and then the debris on the pile.<sup>230</sup>

Cst. Cox and Cst. Dan Bailey also returned to the site at 5 p.m. and started a reconnaissance of the scene to determine the progress made during the daytime operational cycle. Shoring was observed in the Hotel lobby area. Cst. Cox testified that the shoring was the only significant work he recalled having been completed while he had been away from the scene.<sup>231</sup>

**Entry from the front of the stores was not possible because of the collapse. To gain access they breached the back walls of the stores. No dogs were used. No victims were found. Once this search was complete, the crane was ready to be put into operation.**

Following his tour of the site, Cst. Cox was tasked by Sgt. Gillespie to assist the Fire Department to enter the back of the stores facing the collapse area to confirm that there were no victims trapped inside. Entry from the front of the stores was not possible because of the collapse. To gain access they breached the back walls of the stores. No dogs were used. No victims were found. Once this search was complete, the crane was ready to be put into operation.<sup>232</sup>

Cst. Steve Hulsman testified that he was back on shift at 6 p.m. Like the others, he was briefed by Sgt. Gillespie and was designated team leader of the night shift. He was told to continue building the laced-post shoring started by HUSAR/TF3 during the day and to build one more "rigger." HUSAR/TF3 members were still on scene, but Cst. Hulsman did not know what tasks they had been assigned.<sup>233</sup>

The shoring continued while the beam was being cut. It was only once the beam was about to be finally cut loose that Sgt. Gillespie instructed Cst. Hulsman's team to stand down and move away from the area, toward the entrance, for safety. He and his team spent the majority of their shift completing the shoring that HUSAR/TF3 had started on the west side of the lobby.<sup>234</sup>

Sgt. Glavin (HUSAR/TF3) began his shift at 6 p.m. He was briefed by Capt. Chris Rowland. This briefing was the first time he was made aware of what the plan was going to be. At this time, he also learned for the first time that one of the victims was believed to be deceased and the other one was believed to still be alive.<sup>235</sup>

## **Don Sorel, the only HUSAR/TF3 member with rigging experience, arrives in Elliot Lake**

Initially, Don Sorel, an employee of Toronto Water, and a member of HUSAR/TF3, had not been available to deploy with the TF3 team. By 11:45 a.m. he was available to deploy and he arrived in Elliot Lake at 5:45 p.m. on June 24 at Staff Insp. Neadles's request.<sup>236</sup> Several hours after his arrival on site, Mr. Sorel was assigned the task of lifting out the concrete and removing the SUV from the rubble pile. Mr. Sorel testified that before starting the work, Capt. Comella took him to the second floor of the Mall to show him the collapse zone and provide direction on the work to be completed. To the best of his recollection, he was not told that there was a limit on the number of concrete slabs to be removed from the rubble pile. During this reconnaissance, Mr. Sorel was also shown where the victim believed to be alive was thought to be located.<sup>237</sup>

## **5 p.m.: The City of Elliot Lake holds a press conference – a possible fatality is confirmed**

A further press conference was planned for 5 p.m. Prior to it, a meeting was held at which Staff Insp. Neadles, Chief Officer, Insp. Jollymore, and others were present. There was a debate about releasing the information of a possible fatality. The notes from the meeting indicate that Staff Insp. Neadles expressed concern that the longer they waited to release the information, the more the public would think that things were being hidden. Despite his views on releasing the information, he indicated that he was prepared to go along with the majority. Chief Officer confirmed that ultimately the decision to release information about a possible fatality was made during the press conference.<sup>238</sup>

At the press conference, Insp. Jollymore stated that they had a visual sighting of a hand and a foot and that they suspected there was one casualty. In response to a question from a reporter requesting confirmation on the number of victims and casualties, Insp. Jollymore responded that the identification and number of victims were unknown.<sup>239</sup>

## **There was no incident action plan prepared for the night shift – it is developed as things went along**

Capt. Comella testified that he did not believe he was specifically involved in formulating the plan for the second shift, but he was continually working on next steps, evaluating the building and the work to be done throughout the entire deployment. He believed that the priority of the second operational shift on June 24 would be to remove the beam and continue with the shoring. Capt. Comella also testified that the removal of the beam posed a big concern for the group because it was unknown whether it would cause a secondary collapse.<sup>240</sup>

## **Movement is noted at the top of the escalator at 6 p.m.**

The evening operational cycle started at 6 p.m., when Sgt. Gillespie inspected the building and made note of "obvious minor movement of gap at top of stairs."<sup>241</sup> This movement was observed in the penthouse area of the rooftop parking. The gap was located at the top of the stairs which led from the rooftop parking area down to the second floor of the Mall. Sgt. Gillespie testified that the stairs at that location had started to come away from the rest of the building. He recalled that the gap became larger as time went on. He indicated that his observations were made when he was standing on the top level looking at the gap; at that point he had been able to walk right up to the top of the stairs, accessed from the rooftop parking deck.<sup>242</sup>

In addition to observing the movement of the gap at the top of the stairs, Sgt. Gillespie also noted that the beam supporting the staircase and escalator was sagging significantly more than it had on the previous day and was rotating inward from the weight of the concrete slabs on the escalator. Sgt. Gillespie testified that as a result of the sagging and twisting of the beam, he was advised that the plan was to add a tie-back, attached to the beam and secured southward to relieve some of the tension which was causing the beam to twist inward. At this point, the steel jack posts that had been ordered by Cst. Waddick on the previous night had also been delivered.<sup>243</sup> It would appear that the information regarding the plan to add a tie-back had come from a discussion between Sgt. Gillespie and Mr. Cranford.<sup>244</sup>

Cmdr. McCallion had also made notes about the stability of the building; it was still moving and settling and there were concerns about the escalator collapsing. He noted that the beam under the escalator was continuing to bow incrementally, although he had not witnessed this movement himself. He testified that he had probably received this information from Capt. Comella. This 6:15 p.m. note represented the first time the concern with the beam was brought to his attention.<sup>245</sup>

### **6:04 p.m.: Staff Insp. Neadles sends an update – the cranes are getting ready and information is released about the victims**

At 6:04 p.m., Staff Insp. Neadles sent his fifth update to the group, which stated:

Status quo on the Operations. The first of two cranes is set and the second crane is getting set up now.

The team continues to work on the stabilization at the south end.

We are commencing a shift change now. Team 2 is coming on as well as the OPP UCRT Team.

There was a press Conference at 1700 where the info on two victims was released. One being a Rescue.<sup>246</sup>

Staff Insp. Neadles testified that the notation in the update about stabilization at the south end was an error and should have read “north end.” He confirmed that this was in reference to the shoring being performed in the Hotel lobby.<sup>247</sup>

### **The crane is ready to cut the beam**

As of 7:50 p.m., Millennium Crane had completed its setup and the operation for the removal of the beam had started.<sup>248</sup>

Initially, it had been decided that the ironworkers brought by Millennium Crane would weld lugs to the top flange of the hanging beam in order to attach the cables which would be used to hoist it out once it was cut. But after examining the beam, it was determined that there was too much rust on the top flange to securely weld the lugs to the flange. It was decided that they would double-wrap a choker around the beam (with cables) to ensure that it did not slip out of the rigging after it was cut. The boom and load line were angled away from the building, off centre, to offset the load line so that when the beam was lifted out it would be away from the closest wall.<sup>249</sup>

A test lift was performed of the suspended platform that would be carrying the workers. Mr. Selvers testified that such a procedure is always performed in the ordinary course of any crane operation. He said he felt the Ministry of Labour was scrutinizing his procedure but he acknowledged that the officials did not request that the test procedure be carried out. The ministry engineers asked to see the structural certifications for the cranes and the diagram of the procedure to be followed that had been prepared by Millennium Crane. Mr. Selvers confirmed that the ministry did not cause a delay in the operation.<sup>250</sup>



Once the test procedures were completed, two workers were lowered into the collapse area on a work platform suspended by the smaller crane. The beam was wrapped with cable chokers and suspended with the larger of the cranes (165 tonne). This crane would ultimately lift the beam out of the collapse area once it was cut free. A tag line was also attached to the beam to provide greater control once it was cut.<sup>251</sup>

While the beam was being cut, water was sprayed across the collapse area to suppress any fire. Once the cutting of the beam began at approximately 8:00 p.m., the process was uninterrupted.<sup>252</sup> Cst. Cox testified that, while the beam was being cut, he was stationed on the west side of the second level of the Mall monitoring for any potential fires that could ignite from the sparks created by the cutting of the beam.<sup>253</sup>

Once the cutting was completed, the beam swung out but did not make contact with any of the surrounding structures. The two workers were lifted out first and then the beam was lifted out.<sup>254</sup>

All other work in the Mall, other than the fire suppression operations, was stopped while the beam was being cut because of concerns over safety. Capt. Comella testified that only the essential people were allowed in the hot zone – all Mall areas – as a precautionary measure during the beam removal procedure.<sup>255</sup>

Brian Sanders, a regional engineer with the Ministry of Labour, arrived in Elliot Lake at 10:24 p.m. to assume care and control of the removed failed beam. At the time of his arrival, he knew little of what had occurred. All he knew was that there had been a collapse and there was one possible fatality. He had not expected that the rescue operations would still be ongoing so long after the collapse.<sup>256</sup>

After the beam had been removed from the collapse area, the next step involved removing the SUV from the top of the pile. The windows of the SUV were broken to run the rigging equipment through the door frame and lift the vehicle out by the roof.<sup>257</sup>

### **9:04 p.m.: Staff Insp. Neadles sends an update**

At 9:04 p.m., Staff Insp. Neadles provided a sixth update to the group and advised that the two cranes were preparing to cut the beam and that all other work in the Mall had been suspended. At this point he also advised that the number of missing people had been reduced to just two.<sup>258</sup>

### **9:30 p.m.: A fourth sign of life is reported**

At 9:30 p.m., Cst. Bailey and his dog Dare were sent into the Mall to search the rubble pile. This was the first time Dare, a cross-trained dog capable of identifying live and deceased victims, was sent out to search on the pile. Dare gave an indication of a live victim by barking and trying to crawl into a void.<sup>259</sup>

### **9:52 p.m.: CCG meeting**

Another CCG meeting was held at 9:52 p.m. Once again Staff Insp. Neadles was in attendance. At this time, he reported to the group that they would not be able to remove the large piece of concrete slab resting on the escalator, but rather that they would try to support the slabs. He testified that at some point in the evening the decision was made that the concrete slabs on the escalator would not be moved. He further testified that the reference to attempting to support the slabs would have been information he received from Capt. Comella and the engineers. He subsequently confirmed in his evidence that Capt. Comella told him that they would not be able to support the slabs on the escalator. This plan was ultimately deemed not to be feasible.<sup>260</sup>



much the stairs and escalator had dropped. However, the fact that he had tripped on it, when he had not done so previously, raised concerns about movement and he felt that they needed to start monitoring the crack. At that point, Capt. Comella and Messrs. Jeffreys and Cranford decided to continue visually observing the crack.<sup>264</sup>

### **11:30 p.m.: the LifeLocator is deployed and gives the fifth sign of life**

At 11:30 p.m. Cst. Hulsman deployed the LifeLocator device to try to find signs of life.<sup>265</sup> The LifeLocator was described as sensitive equipment used by UCRT that has the ability to detect faint signs of breathing and movement. This was the first time he had deployed the LifeLocator outside training.<sup>266</sup>

He deployed it in an area where he had been told that there had been a live hit by the dog.<sup>267</sup> To deploy the device, he lowered it onto the pile from a basket that he was in about 20 feet above the pile. When he operated the machine, there were a number of rescuers within 15 metres of the LifeLocator. This is contrary to the manufacturer's recommendations.<sup>268</sup>

Cst. Hulsman testified that the results he obtained showed breathing on four occasions; however, the depth of the source of the breathing below the LifeLocator varied. The closest was 2.7 metres and the furthest was 6.2 metres below the device.<sup>269</sup>

### **The decision is made to use the crane to hoist debris off the pile**

Sgt. Gillespie, Mr. Jeffreys, Mr. Cranford, and Capt. Comella discussed how to proceed after the beam was successfully removed from the collapse area. Sgt. Gillespie testified that he proposed that the crane be used to remove the concrete slabs from the rubble pile. In his opinion, the crane was the safest and most expeditious way to proceed. Concerns were raised by Capt. Comella that the pile could become dynamic and start sliding if they started lifting slabs. Sgt. Gillespie testified that he did not have these same worries because no significant movement had been noted in the pile throughout the day. He further testified that Mr. Jeffreys did not seem to have an issue with lifting the slabs out with the crane. Ultimately, Capt. Comella agreed that proceeding in this manner was a reasonable option and indicated that he wanted two HUSAR/TF3 and two UCRT members as part of the rigging crew. Sgt. Gillespie agreed and there was consensus that the Millennium Crane workers should not be rigging on the pile. Rigging involves placing a chain, webbing, or straps around an object to be lifted with a crane. The extent of their knowledge and experience was unknown. Mr. Jeffreys agreed with the plan to start hoisting out slabs of concrete, provided that only UCRT and HUSAR/TF3 members would do the rigging.<sup>270</sup> Sgt. Gillespie testified that all but two UCRT members had Level 2 training for rigging but he did not know how many of the HUSAR/TF3 members were similarly trained.<sup>271</sup>

The evidence of the time when the concrete slabs were rigged and hoisted out of the collapse area differed from witness to witness. Many testified that it had been difficult to keep track of the time and acknowledged that, to the extent they had prepared notes, the time indications could be incorrect. According to Sgt. Gillespie's notes, the removal of the concrete slabs did not start until 10:45 p.m.<sup>272</sup> whereas Cst. Waddick's notes have the work starting at 8:30 p.m.<sup>273</sup> Fortunately, the difference between the notes of Cst. Waddick and Sgt. Gillespie is inconsequential.

Before starting the rigging and hoisting on the pile, Mr. Sorel testified, the first thing he and Cst. Waddick did was create an escape route for the riggers. The location identified for the escape route was in the northwest corner of the collapse zone. Mr. Sorel testified that they worked on the escape route and the rigging and hoisting of the slabs off the pile at the same time.<sup>274</sup> The procedure for removing the concrete slabs involved rigging, then carefully lifting the concrete to be hoisted. Initially the piece would only be lifted a few inches to see if it would crumble or be stable enough to be lifted out whole.<sup>275</sup>



## **A rotated beam is noticed and it is determined that the SUV needs to be removed**

Mr. Cranford testified that according to his notes, he was called to return to the site at 2:00 a.m. on June 25 to assess a beam which was noted to be rotating. He explained that the crew had been building laced-post shores on the west side, behind the beam which was believed to be rotating. According to Mr. Cranford's notes, the SUV had not yet been removed from the pile and was determined to be the cause of the rotation. It was observed that the SUV was resting on a beam which was connected to the rotating beam.<sup>276</sup> The vehicle was moving up and down on the beam as the rigging crew was working. Mr. Cranford testified that, as a load was being moved around from the rigging, the beam could be seen to be rocking a little bit, causing it to rotate more.<sup>277</sup> Because of the movement seen in the beam, it was decided that the vehicle would be moved so that they could confirm that the rotation of the beam was caused by the weight of the SUV and not some other source.<sup>278</sup>

The work was stopped while Mr. Cranford examined the rotating beam. This stoppage was unrelated to the crane operations. Once Mr. Cranford had completed his review the work resumed.<sup>279</sup>

## **The SUV is hoisted out and the rigging of the concrete slabs continues**

Before they could move the SUV, two pieces of concrete slab needed to be removed in order to provide an escape route for the rescuers performing the rigging.<sup>280</sup> Cst. Waddick testified that when the SUV was removed there was some swinging from the crane, but nothing of concern. As they started lifting the SUV, it was noted that one of the tires was pinched between pieces of concrete. Cst. Waddick gave direction to the crane operator to take some of the load (to pull up on the car); he then directed the operator to stop and lower the load, and the tire pulled free. This action caused the boom and the SUV to swing. There was no contact with the rubble pile; there was contact with a beam, but no movement of the pile or any of the structural elements was observed. The rigging for the removal of the vehicle was done by Cst. Waddick, Cst. Cox, and two HUSAR/TF3 riggers, one of whom was Mr. Sorel.<sup>281</sup>

According to Cst. Waddick, rigging the pieces of concrete slab required lifting the slabs up with prybars in order to get the rigging straps/cribbing underneath. In many cases it was necessary to lift the pieces up at least four times to get the straps/cribbing in place to ensure that the load was balanced.<sup>282</sup>

The slabs being removed were from the general area where the victims were believed to be located. Cst. Waddick stated that he was not relying on the signs of life which had been reported up to that point. He explained that, although the rescuers assumed the victims were at the south end of the pile, they could not just start removing concrete from that area, because it would have created a slide on the north side of the pile. The approach used throughout the night was to remove pieces progressively down through the pile. The higher pile on the north end was removed to stabilize the area so that they could begin removing the debris from the area where they believed the victims were located. Throughout the rigging and hoisting operation they continued to use cameras to check the voids because they did not know exactly where the victims were located. Cst. Waddick testified that they eventually located Mrs. Doloris Perizzolo next to a bank of payphones on the east side (albeit not until June 27) and Ms. Lucie Aylwin was found two to three metres west of Mrs. Perizzolo's position.<sup>283</sup>

Cst. Waddick testified that, the entire time he was rigging and hoisting pieces of concrete slabs from the rubble pile, he did not observe concrete pieces or debris slipping and falling out of the cribbing onto the pile. He further testified that he did not experience any movement, vibration, or groaning noises from the steel or any other sounds that would suggest or indicate any kind of movement of the building or the pile.<sup>284</sup>

The rigging and hoisting operations were supervised during the night by Sgt. Gillespie, Mr. Lacroix, Mr. Jones, and Capt. Comella to ensure that none of the riggers positioned themselves into a dangerous location, especially when the lifts were occurring. They were also monitoring for overhead hazards.<sup>285</sup>

Sgt. Gillespie testified that he could not recall how many slabs were removed during the night of June 24 but he was certain it was more than three. He explained that initially they had talked about lifting a few slabs to see how things developed, but there was no hard and fast number of slabs to be lifted. It was agreed that they would proceed slowly to ensure that the operation was as safe as possible. He acknowledged that initially there may have been discussions about lifting a limited number of slabs; however, during the night they were constantly assessing the situation as the slabs were being lifted. Sgt. Gillespie testified that he and Capt. Comella stood beside each other for many hours while the rigging was occurring and removing only three slabs was not discussed.<sup>286</sup>

Mr. Sorel testified that the rigging and hoisting operations were stopped on two occasions during the night, not for safety reasons, but to do a call-out. He testified that for the call-out Greg Law, a member of HUSAR/TF3 and one of the riggers assisting with hoisting the slabs off the pile, would get down on his hands and knees and yell into a void in the pile and state: "Search-and-rescue. We're here to help you, we're coming to get you. If you can hear us, please give us an indication, tap or call-out."<sup>287</sup> The call-outs by Mr. Law were performed twice. No response was received.<sup>288</sup>

Capt. Comella testified that, during the night and into the early hours of Monday morning, two concurrent operations were being performed: the rescue shoring which was coming in from the north, and the shoring from the west toward the pile. Contrary to Sgt. Gillespie, he testified that there had been a discussion about removing three pieces of concrete, because the LifeLocator had a hit indicating that there was a victim close to the surface. He said the rescuers were continuing with the tunnelling, which simply meant that the team was moving forward into the pile; he explained it was a loose term that they used and that going down a hallway would be considered "tunnelling."<sup>289</sup> It did not mean actually building a tunnel.

Capt. Comella further testified that the rigging operation with the crane for the removal of debris was not the main operation on the night of June 24 and the early hours of June 25. He explained that the crane was assisting the rescuers with the removal of debris because the LifeLocator had indicated that the victim appeared to be close to the surface. He testified that, but for the information received from the LifeLocator device, they probably would not have used the crane to remove debris. He explained that the rescuers would have simply continued moving forward toward the pile with the shoring activities. He explained that the reticence to conduct crane operations above the location of a victim is lack of control. Once a piece is lifted, a crane might fail, a cable could snap, or a piece could break apart, endangering the victim. Those types of issues do not arise when tunnelling because every piece encountered during the advance is stabilized by first using lumber.<sup>290</sup>

I have difficulty understanding the logic of that reasoning. While tunnelling will certainly protect the rescuers, I fail to see how it assists in removing large pieces of concrete, particularly when time is of the essence. I acknowledge the validity of the described risks when using a crane, but given the dynamics of the collapse, as well as the weight and size of the pieces overlying the victims, it seems to me that crane operations in the Elliot Lake rescue were vitally necessary. More related training and experience might have given the rescue teams more confidence in their use.

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The shoring operations in the area of the Hotel lobby continued while the crane was removing the beam but were stopped while the SUV was being lifted. Sgt. Glavin testified that the SUV had been sitting on a beam attached to the area above the shoring work, making the interruption necessary in the event of a mishap during the lift.<sup>291</sup>



## Work stoppages

Cst. Hulsman recalled that there were some brief work stoppages while completing the shoring in the night of June 24. Although Mr. Lacroix and Mr. Jones were on site that night, the stoppages were ordered by Capt. Rowland, the night shift squad leader, ostensibly because of concerns about a twisting I-beam. Sgt. Gillespie was advised and he ordered the team back to work. The reasons for the indecision were not explained.<sup>292</sup>

## The families of the victims are not provided with adequate information in the first 24 to 36 hours following the collapse

Robin Kerr with Victims Services of Algoma testified that the families at the Collins Hall had not received any updates since 11 p.m. on June 23. At 3:30 a.m. on June 24, she went to the OPP detachment to request that a police officer go to the Collins Hall to provide an update to the family members. When she arrived at the detachment, she was unable to gain entry. An OPP cruiser drove by and she managed to flag it down and asked the two officers if someone could go to the Collins Hall to provide an update. No one went to provide an update until two hours later.<sup>293</sup> In accordance with Ms. Kerr's notes of the events following the collapse, Staff Sgt. Dan Esposto, the communications officer assigned to the families, went to the Collins Hall and advised the families that the search was still progressing and that HUSAR/TF3 was on its way.<sup>294</sup>

Ms. Kerr described the update provided by Staff Sgt. Esposto as very short and abrupt. She indicated that he delivered his update to all those present at the Collins Hall but that Mrs. Perizzolo's family were outside at that point. Ms. Kerr asked the officer to wait so she could go outside and get them. He ignored her request and proceeded to provide an update anyway. Ms. Kerr testified that generally everyone present for the update seemed content; they wished that they'd been provided with more information during the night but were thankful to have received something. She further testified that once Staff Sgt. Esposto had finished giving his update, he pulled her aside and asked that she not do that again. He told her that he would come and give the updates, and they could be shared by others.<sup>295</sup>

Insp. Jollymore testified that from his perspective the OPP did a good job keeping the families informed about what was going on. He said that he ensured that his counterpart on the night shift went to the Collins Hall every two hours to provide an update. He also indicated that he had the Critical Trauma Support Team deal with the families on Sunday and on Monday as well.<sup>296</sup>

Gary Gendron, Lucie Aylwin's fiancé, testified that on the morning of June 24, he returned to the Collins Hall to see if any new information was available. Although he and the other families had been told that they would be receiving updates every two to six hours, this was not occurring. The families were getting more information from the radio than they were from the individuals in authority. Mr. Gendron recalled receiving information at some point on June 24 that a heartbeat had been detected and that the rescuers had heard tapping coming from the rubble pile.<sup>297</sup>

Ms. Kerr raised the lack of information with Insp. Jollymore, who apologized and indicated that he would ensure someone would attend to update them. Following this discussion, Ms. Kerr indicated that the updates became more frequent during the day on June 24 and were being provided by a designated OPP officer, Cst. Laura Hicks. Ms. Kerr testified that Cst. Hicks would go to the Collins Hall and speak to the families personally. Ms. Kerr testified that the updates from the officer created a good flow of information between the people in authority and those at the Collins Hall.<sup>298</sup>



Darrin Latullipe, husband of Teresa Perizzolo, testified that at one point he was informed by Staff Insp. Needles that signs of life had been detected and that one deceased victim had been located by a cadaver dog. He said that they were told that the building was being shored up and that at that point in time the escalators were the major issues.<sup>299</sup>

During the night of June 24 into the early hours of June 25, Staff Sgt. Esposto (although misidentified in Ms. Kerr's testimony as Cst. Esposito) attended at the Collins Hall every two to three hours to provide updates. The last update was provided at 6:40 a.m. on June 25. After that final update, no further information was provided to those at the Collins Hall until 2:00 p.m. on June 25.<sup>300</sup>

Ms. Kerr called to the North Bay dispatch centre and was put through to an officer at the Elliot Lake OPP detachment. This person had no information to share. Ms. Kerr requested that someone attend at the Collins Hall to provide an update and emphasized that the families needed to know that the rescuers were continuing to work and needed to be told what was happening. However, no one came to the Collins Hall to provide an update. In her view, the updates should have been coming from someone with a badge because the representation of authority gives the families confidence in the accuracy of the information being given to them.<sup>301</sup> Ms. Kerr described the effect lack of information has upon the public as follows:

The turmoil grows, and speculation rises, and we had individuals from the community coming in and starting to spread what could have been rumours. We didn't know. So we worked at our utmost to try and stop that because we didn't want rumours and speculation spreading throughout the hall. And without information, you begin to think the worst instead of what may be the outcome. So it is very, very important that the victims are involved and always brought up to date in what is occurring.<sup>302</sup>

Victims Services ultimately made the decision to put workers at the main door to the Collins Hall to stop people entering. As people arrived, they would be asked what their purpose was (what they needed, who they were looking for) and then directed if necessary to other services available in Elliot Lake. These efforts were put in place in an attempt to stop the flow of misinformation being relayed to the victims' families. Ms. Kerr testified that she assumed misinformation spread nonetheless but could not provide specific examples.<sup>303</sup>

## Messaging being provided to the community at large

Insp. Jollymore testified that as of midday on June 24, he was of the view "[t]hat we really did not know who was trapped or who wasn't trapped in the rubble and that we had some reports of life, and that is all we could confirm."<sup>304</sup> He testified that Chief Officer had a different view of the casualties and was of the opinion that an announcement should be made that a foot had been found without a pulse, which would mean announcing that there was a confirmed death. Insp. Jollymore did not agree with this position because there was no way of knowing if the foot had been severed or pinched. He felt that in the circumstances it would have been irresponsible to announce that someone had died. He testified that he would have been fine with advising that a foot had been found but he was not prepared to use that information to confirm a death. Chief Officer ultimately agreed to go along with the decision not to announce that someone had died.<sup>305</sup>

It was pointed out to Insp. Jollymore during his testimony that an EMS technician had confirmed that the person was dead on June 23. He responded that it was his understanding that an EMS technician did not have the authority to make a declaration of death and that OPP protocol dictates that, when it is not clear if a person has died, a pronouncement of death from a coroner is required. From his perspective, the pronouncement of death of that victim was not going to occur until the coroner took charge of the scene, which was not going to happen until a body was recovered. He did confirm that there could be times when an EMS technician could

pronounce death, if there are obvious signs, such as decapitation or if the person has clearly been deceased for a long period of time. However, in his opinion, he needed more than a foot with no pulse to be able to make the pronouncement of death.<sup>306</sup>

When asked about informing the families about a death, Insp. Jollymore testified that he would not have known which family to inform, as he did not know who had died. He thought that, notwithstanding his opinion, ultimately it was up to the City of Elliot Lake or possibly Chief Officer (he was unsure) to decide what information

to release.<sup>307</sup> He testified that he would not have objected if the City had released information stating that they suspected there was a casualty, which by definition would include a death or an injury. However, this was not done.<sup>308</sup>

**There are times, of course, when the need for confidentiality outweighs public disclosure. But in a situation like the one that existed in Elliot Lake, simple humanity and the preservation of public order dictated frankness, openness, and clarity rather than secrecy.**

I disagree with Insp. Jollymore's approach. Telling things as they are may sometimes be inconvenient or hard, but if one remains silent, others will invent more inconvenient versions. That is how rumours and falsehoods spread. Obviously, truth sometimes needs to be well told, but told nevertheless. There are times, of course, when the need for confidentiality outweighs public disclosure. But in a situation like the one that existed in Elliot Lake, simple humanity and the preservation of public order dictated frankness, openness, and clarity rather than secrecy.

## June 25

### 12:03 a.m.: Staff Inspector Neadles sends an update

At 12:03 a.m. on Monday, June 25, Staff Insp. Neadles sent out a seventh update to the group. He advised that the team was removing debris and shoring the necessary areas to allow the rescuers to continue moving toward the victim. He also advised that the crane had been used to remove the hanging beam and was being used to assist with removing slabs of concrete to expedite access to the victim.<sup>309</sup>

### 2:20 a.m.: Cmdr. McCallion sends an update

At 2:20 a.m. on Monday, June 25, Cmdr. McCallion sent out an eighth update to the group and advised that the crane had removed the SUV along with a few pieces of concrete. He advised that the structural integrity of some columns was still in question but that the removal of the debris was continuing. He indicated to the group that there were no further updates to report on the status of the victim.<sup>310</sup>

### Information is received regarding the condition of the victim believed to be alive

In the early morning hours of June 25, Dr. Michael Feldman, the HUSAR/TF3 physician, learned that one of the missing persons believed to be trapped in the rubble pile was a brittle diabetic. This information had been provided to him by a local doctor.<sup>311</sup> The survival chances of a person with this medical condition in a rubble pile is addressed in detail in Chapter 8, The Victims: Cause and Time of Death.

## The possibility of shoring underneath the beam supporting the escalator is reviewed once again

According to his 3:45 a.m. notes, after examining the beam rotating because of the weight of the SUV, Mr. Cranford again discussed shoring the beam under the escalator. He could not recall whom he had this discussion with, other than to indicate that it was one of the rescue commanders. He testified that earlier he had spoken with UCRT and Capt. Comella about ways to support the escalator. He explained that at this point in the operation the work on the rubble pile was progressing and the rescuers were anticipating moving into the area of the escalators. He noted that there were steel hollow structural section posts (HSS posts or steel tubes used in construction) available on the site that would have been suitable for shoring under the escalator.<sup>312</sup>

## The riggers have been working all night and into the early morning hours

At 4:08 a.m., the rigging crew took a break. They had been rigging on the pile since approximately 11:00 p.m. on June 24. During this rest period, the pile was again searched with the dogs and with the LifeLocator.<sup>313</sup>

As the crew continued to work on the pile, the pieces became more difficult to rig and hoist. Sgt. Gillespie testified that at the beginning the pieces were more intact and easier to remove; as the workers went lower into the pile, those pieces required more adjustment before they could be lifted out. It was becoming a more time-consuming task.<sup>314</sup>

Capt. Comella returned to the scene at 5:45 a.m. He met up with Sgt. Gillespie, who was still acting as safety monitor for the crew rigging on the pile. He noted that more slabs had been removed than originally planned. He was not concerned as it was normal that they would have re-evaluated the plan as the work progressed.<sup>315</sup>

## The dogs are sent in again to search but yield no concrete results for a live victim

At 4:00 a.m., both Sgt. Fowlds and Cst. Bailey returned to the pile with their dogs, Ranger and Dare. Cst. Bailey accessed the pile with Dare first. During this search, Sgt. Fowlds left the area, not wanting to be influenced by where Cst. Bailey and his dog were indicating on the pile. Sgt. Fowlds returned to the pile once Cst. Bailey and Dare had finished their search and had no conversation with him. He began searching the pile with Ranger in the area where he had indicated the first time. Ranger deployed off lead (without a leash and harness) from the north end of the pile. At this point, the collapse area had changed because of the removal of the SUV and concrete slabs. Given that debris had been removed at this point, Ranger was able to search a larger area, but also searched the same area that had been part of the previous search. Ranger moved up and down the pile. Although the dog continued to work the area with a lot of interest, he did not indicate on any area. Sgt. Fowlds testified that Ranger had caught a scent and was trying to pinpoint its location by moving back and forth across the pile, but there did not appear to be enough of a scent present to cause Ranger to bark. Sgt. Fowlds testified that Ranger had searched the pile for approximately 10 minutes. He called Ranger off the pile and then reported to Capt. Rowland that there had been no indication from Ranger, although he had shown a lot of interest in the same area where he had indicated the day before.<sup>316</sup>

Cst. Bailey's notes indicate that he was asked to take Dare back onto the pile at 5:03 a.m. Unlike the first time, when he could not go beyond the entrance doors near Foodland, he could access the pile with Dare and observe his actions and demeanour. The indications given by Dare during this search caused Cst. Bailey to believe that he was no longer indicating on a live victim, but he was not certain.<sup>317</sup>



## The LifeLocator is used a second time

Cmdr. McCallion testified that he was informed that signs of life had been detected with the LifeLocator. His notes state that the detection was made at 4:00 a.m. and there were indications of breathing at a distance of 2.6 metres below the location of the device. The work and shoring continued in the location where indications of breathing were identified with the LifeLocator. He testified that, when he was provided with the results from the LifeLocator, the information did not qualify the strength of the reading. He recalled that, while the LifeLocator had been deployed, there were people within 15 metres of the device. Being told that there was breathing detected 2.6 metres below where the device had been placed on the pile would have meant that the victim was underneath the concrete pad of the bottom floor of the Mall. This made no sense. He questioned the accuracy of the results from the device but did not voice his suspicions then. A few hours later, likely before noon on June 25, he recalled giving the results to Staff Insp. Neadles, who advised him that they needed to take the information for what it was, namely, that it was showing that there was something there. Cmdr. McCallion explained that he trusted that the UCRT officer using the device was qualified, but he questioned the value of the results.<sup>318</sup>

The LifeLocator was deployed for the second time at approximately 4:30 a.m. while the riggers were taking a break. Because the hanging beam and some of the concrete slabs had been removed, Cst. Hulsman was able to deploy the device without having to suspend it from a rope. Sgt. Gillespie felt that the results would be more reliable. The device would be used where Cst. Bailey had advised that his dog Dare had just moments earlier shown an interest. When the LifeLocator was deployed, it provided a “faint” indication, which meant that it was difficult to confirm breathing.<sup>319</sup>

Cst. Hulsman's notes indicated that he deployed the LifeLocator at 5:30 a.m., not 4:30 a.m. Although his notes and Sgt. Gillespie's differ, there is no indication that the LifeLocator was deployed more than once in the early morning hours of June 25. Cst. Hulsman explained that during the second deployment, the device was placed only once in the centre of the pile in the same location as on the earlier deployment; he moved to the northwest corner to get as far away from the device as he could without getting off the pile. He believed that he was approximately 15 to 20 feet away from the device, but still within the 15-metre recommended exclusion zone. Cst. Hulsman explained that it was recommended by the manufacturer that no persons should be located within a 15-metre radius of the area where the device was to be deployed in order to avoid the potential that the LifeLocator could pick up the breathing and movement of these other persons, as opposed to that of the victim under the pile. The training received by Cst. Hulsman and the 15-metre exclusion zone is discussed later in this chapter. There were other workers in that zone. The device again gave a positive reading for breathing, but on this occasion it took longer for the breathing indication to display on the monitor. There was no movement indication this time around. He testified that he had the same level of confidence in the results for both deployments.<sup>320</sup>

Sgt. Glavin, a technical search specialist, watched the deployment of the LifeLocator out of professional curiosity.<sup>321</sup> He said that when it was deployed there were eight to 10 people less than 12 to 14 metres from the machine.<sup>322</sup> He said that two OPP officers were involved but Sgt. Gillespie was not one of them. He thought that the officers were not confident in their ability to use the LifeLocator. He based this judgment on their body language and conversation.<sup>323</sup>

The results were reported by the officers who said: “We have signs of life 12 metres.” Sgt. Glavin said that they indicated that 12 metres was below. Since the machine was nearly on the floor, it occurred to him that the LifeLocator was picking up the breathing of someone in the 12-metre range.<sup>324</sup>

## Search cameras are used in the pile – fabric is seen on the camera

Sgt. Gillespie also testified that two HUSAR/TF3 members accessed the pile and performed a search with cameras and identified what appeared to be red and blue clothing. He testified that the HUSAR/TF3 members could not be certain it was clothing, but they believed it could be. This was the first time that they had seen fabric or clothing in the pile. Before this search, the only thing that had been seen other than concrete was insulation, wires, and construction debris. Until that point, they had no visual evidence that could indicate a person. The searchers were unsure if the objects believed to be clothing were on a person, but the image was in the same area where they believed the living person was located.<sup>325</sup>

## Issues raised with OPP safety practices

Cmdr. McCallion testified that when he returned to the scene for the shift change on the morning of June 25, Capt. Rowland approached him with concerns regarding the manner in which the rigging operation had been conducted. He explained that his team had been building laced-post shores overnight and was concerned that, when the riggers were lifting and lowering slabs, they had not been communicating with him and his team. Capt. Rowland explained to Cmdr. McCallion that his team was 16 to 17 feet away from the rigging operation and, as the debris was being lifted, any swinging or failure could have impacted his team, particularly as they had no visual contact with the rigging operation and could not anticipate an impending incident.<sup>326</sup>

**Capt. Rowland explained to Cmdr. McCallion that his team was 16 to 17 feet away from the rigging operation and, as the debris was being lifted, any swinging or failure could have impacted his team, particularly as they had no visual contact with the rigging operation and could not anticipate an impending incident.**

Cmdr. McCallion acknowledged that a safety officer was watching the rigging operation and another safety officer was watching the team building the laced-post shores, and that these two safety officers should generally be able to talk to each other. He also confirmed that the UCRT and HUSAR/TF3 radios were not compatible with each other.<sup>327</sup>

Cmdr. McCallion testified that he valued Capt. Rowland's opinion and, if he was concerned, he felt it would be justified. He did not ask Capt. Rowland if he had raised his concerns with the riggers during the overnight operation.<sup>328</sup>

Following his discussion with Capt. Rowland, Cmdr. McCallion approached Sgt. Gillespie and relayed the concerns that had been raised. Cmdr. McCallion testified that Sgt. Gillespie said he did not understand why Capt. Rowland had not approached him at the time. From his standpoint, having watched the rigging throughout the night and into the early morning hours, everything had been done safely.

Cmdr. McCallion testified that, while he was talking to Sgt. Gillespie about the matter raised by Capt. Rowland, he witnessed Mr. Sorel working in an unsafe manner. He saw Mr. Sorel lying down on his side with his arm underneath one of the slabs up to his shoulder. Cmdr. McCallion reprimanded Mr. Sorel. The slab under which Mr. Sorel had his arm was over the area where Mrs. Perizzolo was believed to be located. Cmdr. McCallion instructed Mr. Sorel that he was not to put himself at risk for a victim who was being treated as deceased. Cmdr. McCallion testified that Mr. Sorel took exception to this instruction and said that it was necessary to get the victim out. Cmdr. McCallion repeated his instruction that the rescuers needed to be working on the live victim. Mr. Sorel ultimately followed the instructions given to him.<sup>329</sup>

Sgt. Gillespie addressed the exchange which occurred between him and Cmdr. McCallion and the allegation that UCRT was working in an unsafe manner on the pile. He confirmed that he met with Cmdr. McCallion at 6:35 a.m., just before a shift change. Cmdr. McCallion informed Sgt. Gillespie that Capt. Rowland had complained about unsafe practices of the rigging crew. Sgt. Gillespie testified that Cmdr. McCallion accused him and his team of operating in an unsafe fashion the entire night. Sgt. Gillespie testified that he stated that all levels of safety had been maintained. He explained to Cmdr. McCallion that he, Capt. Comella, and two Ministry of Labour personnel had been present and observed the operation throughout the night and that none had expressed any concerns. He said he felt personally targeted by Cmdr. McCallion's accusations and testified that the exchange became heated.<sup>330</sup>

Sgt. Gillespie's notes taken that night reflect much of what he expressed to Cmdr. McCallion during the exchange, in particular:

... pushing forward with every possible timely method to gain access to the likely viable patient signs of life as of 04:30 and time is against us to save this person. We must continue to save this person. We are operating with the utmost safety and have gained significant towards our goal throughout the night. If we are to save this person, we must continue. Riggers still able to continue. Never once were any of Roland's concerns brought to me personally, either Task Force 3F-3/OPP radio – I had both, as well as TFS command and we were never made aware of his concerns despite his obvious ability to do so. Requested rigging crew from day shift TF3 to continue. Denied for this request from him. Advised McCallion as TF3 not available to provide more relief for our members that we will continue two large slabs only to be removed to allow gain access.<sup>331</sup>

Cmdr. McCallion testified that he believed the riggers were working under a "false sense of security" because the area where Mr. Sorel and Cst. Waddick were working was very close to the beam below the escalator and the overlying slabs.<sup>332</sup>

Mr. Jones testified that he was on the scene and observed some of the rigging and hoisting of the slabs that had occurred throughout the night. He indicated that if he had seen anything of concern or anyone working in

an unsafe manner he would have spoken to the individual involved or to his supervisor. He did neither. As far as he knew, no one from the Ministry of Labour had any discussions with the rescue workers about unsafe practices that night.<sup>333</sup>

**In order to ensure that the response runs smoothly and that all rescuers are kept safe, it is incumbent upon all those in a leadership or command position to ensure proper communications between all the parties.**

Capt. Rowland was not called as a witness to testify. In order to ensure that the response runs smoothly and that all rescuers are kept safe, it is incumbent upon all those in a leadership or command position to ensure proper communications between all the parties. If Capt. Rowland had concerns about the manner in which the work was being carried out by the riggers, he should have approached Sgt. Gillespie at the time to raise those issues and arrive at a solution to ensure that all the workers in the building could continue to work safely.

Sgt. Gillespie had a HUSAR/TF3 radio in his possession. If Capt. Rowland had concerns, he should have expressed them at the time directly to Sgt. Gillespie, rather than waiting to express them after the fact to Cmdr. McCallion. This exchange further illustrates the communication and coordination problems that existed between the two teams.



## **The results of the second deployment of the LifeLocator are relayed to HUSAR/TF3 and influence the decision whether to continue with the crane operation**

Sgt. Gillespie testified that, although he relayed the information about the results obtained from the use of the LifeLocator in the early morning hours of June 25, he did not express any reservations to Cmdr. McCallion about the accuracy of those results. He explained that he had fewer concerns about the manner in which the LifeLocator was employed the second occasion and believed that the device was indicating that there was a person underneath the pile.<sup>334</sup>

Capt. Comella testified that the results of the deployment of the LifeLocator device influenced the decisions made regarding next steps and in particular the decision to send the riggers on the pile to remove the concrete slabs. It was believed at that point that the removal of three more slabs could potentially expose the victim.<sup>335</sup>

Capt. Comella testified that the UCRT team was adamant that it was close to the victim based on the readings from the machine, and therefore the decision was made to risk the health and safety of a few rescuers in order to remove concrete slabs in the hopes that the victim was close to the top of the pile. He said they had agreed to remove smaller pieces that were identified as having less chance of affecting the dynamics of the collapse structure.<sup>336</sup>

Staff Insp. Needles testified that he returned to the site in the early morning hours of June 25, although he could not recall the time. He believed he was advised at that time that the canines had been deployed on the pile in the same time frame as the LifeLocator was used for the second time. He was not told that Sgt. Fowlds's dog had also been deployed on the pile but had not given a positive indication of a live human scent. He testified that he was under the impression the UCRT dog had returned with a positive hit.<sup>337</sup>

## **UCRT pleads with HUSAR/TF3 to allow the rigging to continue**

Sgt. Gillespie testified that after their heated discussion, he and Cmdr. McCallion were able to put aside their differences and discuss the next steps. At that point it was believed that they were getting close to the trapped person. This belief was based on the information from the search cameras (fabric or clothing had been seen), the canines, and the LifeLocator. At this point, the four riggers were at the end of their operational shift. HUSAR/TF3 was scheduled to take over for the day shift but did not have any riggers to replace the ones who would be leaving the pile. Sgt. Gillespie requested permission from Cmdr. McCallion to allow the riggers who had been working through the night to continue for another hour or so to lift a few more slabs. Sgt. Gillespie acknowledged that, if Cmdr. McCallion pulled the two HUSAR/TF3 riggers from the pile, then UCRT would be unable to continue hoisting slabs out of the collapse area, as no one was available to provide relief. Cmdr. McCallion agreed to allow them to continue and it was agreed that the riggers would lift two more slabs.<sup>338</sup>

Cst. Cox confirmed that he was advised by Sgt. Gillespie that HUSAR/TF3 did not have any riggers on the day shift. It was decided that Csts. Cox and Waddick along with HUSAR/TF3 riggers, Mr. Sorel and Mr. Law, would go back on the pile. The operations continued for approximately three hours. The riggers stopped working at 10:00 a.m. on June 25.<sup>339</sup>

Sgt. Gillespie testified that they selected the last two pieces of slab to be lifted out. Capt. Comella, Cmdr. McCallion, and Sgt. Gillespie all watched this final operation. The first of the two final pieces was taken out in two pieces because it was too unstable to take out in one piece.<sup>340</sup> Sgt. Gillespie testified that the riggers could not get their slings underneath the second piece of concrete. He explained that they believed this second slab was over the person thought to still be alive. Because they could not get their slings underneath, the plan was to drill bolts into the concrete to be able to lift the slab just high enough to get the slings underneath so it could be rigged properly and lifted out. While someone was sent to find the bolts and before the second piece of slab could be lifted, Capt. Comella requested that Sgt. Gillespie go with him on the rooftop to inspect the crack at the top of the escalator and adjoining stairs. They noted a significant visual change in the crack from the previous inspection. After the inspection of the condition of the crack at the top of the escalator, the riggers were pulled off the pile.

### **The CCG meets at 8:30 a.m.**

At 8:30 a.m. the Community Control Group met once again. Staff Insp. Neadles was present and advised the members that the beam had been cut and removed and that the crane was used to rig and remove the SUV and concrete slabs. The group was also advised that the shoring activities were continuing.<sup>341</sup>

In addition, he advised that the canines had been sent in to perform a search at 4:00 a.m. and they continued to believe someone was alive and still breathing under the pile. He also advised them that the cameras had been used and it was believed that they saw someone in the rubble.<sup>342</sup>

Staff Insp. Neadles testified that the information he provided to the group had come to him from Cmdr. McCallion. He further explained that the reference in the notes to the belief that someone was still breathing was a reference to the results from the LifeLocator. He explained that there was never mention of the fact that the canines had made live hits because he did not think it was necessary to advise every time a dog was sent onto the rubble pile. In his view, by stating that there was no change in the victim status, he was advising them that the victim was believed to still be alive. From his perspective, the members were not looking to know which tactics were being used at the scene. They simply wanted to know the results.<sup>343</sup>

Chief Officer also advised the group that the rescuers were hoping to get people out of the pile by the late afternoon and that three more slabs would be removed from the rubble pile.<sup>344</sup>

### **The Elliot Lake collapse is the first time the LifeLocator is used**

Cst. Hulsman testified that the Elliot Lake collapse was the first time the LifeLocator had been used by the UCRT in a non-training situation.<sup>345</sup> He said that he had been involved in procuring the device and that the training received was not extensive. The unit came with a training DVD which was approximately 16 to 17 minutes long. He explained that it was a simple piece of equipment to use. Hands-on training was also provided by the manufacturer.<sup>346</sup>

The unit is manufactured by Geographical Survey Systems Inc. (GSSI), an American company in New Hampshire. Cst. Hulsman testified that the hands-on training provided by GSSI lasted approximately three-quarters of a day and included an in-class PowerPoint presentation after which those in attendance proceeded outside to the simulated collapse structure located at the UCRT Bolton detachment.<sup>347</sup>

During his testimony, Cst. Hulsman demonstrated how the LifeLocator device is operated. He explained that the manufacturer recommends a personnel exclusion zone of 15 metres (no people, including the operator) around the area where the device will be deployed. The machine is then placed on the ground and the operator selects the “run mode” or “expert mode.” He also explained that the manufacturer claims the device can detect movement up to 10 metres away from the antenna and breathing up to eight metres from the antenna. Cst. Hulsman confirmed that certain things could cause interference, such as the failed beam swaying in the wind and radio frequencies emitting from the walkie-talkies used by the rescuers.<sup>348</sup>

Cst. Hulsman explained that in Elliot Lake the device was deployed in “run” mode because if the device is run in “expert” mode there is a possibility that shallow breathing could be missed. Cst. Hulsman testified that the collapse had occurred approximately 36 hours before he used the LifeLocator; he assumed that, if he was going to get any signs of life, it was going to be breathing, and possibly very shallow breathing. He testified that in his opinion using the device in run mode was the most reliable method of operation and he also had not been trained to read the data produced in expert mode.<sup>349</sup>

Sgt. Gillespie acknowledged that the LifeLocator was not used as recommended by the manufacturer because it was hung from a rope. He therefore had a lower level of confidence on the information generated by the device. When asked about the use and effectiveness of equipment like the LifeLocator and dogs, he explained that he would prefer basing his decisions on aggregate results rather than those emanating from a single source, technological or animal. He could not recall if he had relayed his views on the reliability of the results received from LifeLocator to Capt. Comella. He agreed that Capt. Comella would not necessarily have appreciated that there could be a grey area and that the results from the device did not provide a definitive answer.<sup>350</sup>

## Issues with the LifeLocator – discussions with GSSI

In mid-January 2013, Cst. Hulsman contacted GSSI because he had received information from his colleagues about a potential inconsistency between his results and the findings of the pathologist. Specifically, the pathologist had indicated death would have occurred relatively quickly after the collapse. This view was inconsistent with the results he obtained, which showed breathing more than 24 hours after the collapse. He contacted GSSI to find out why or how this inconsistency could have occurred.<sup>351</sup>

Cst. Hulsman explained that, unbeknownst to him, the machine had reset during the deployment, wiping out the date and time until he went back to review the data after the deployment. Although this did not affect the operation of the machine, it did affect his ability to identify the files generated by the device that related to the Elliot Lake deployment. He explained that there were 15 files on the device and he identified three that appeared to be from Elliot Lake. Those were the three he sent to GSSI for review and comment. He confirmed that there was no way of knowing definitively whether the files reviewed by GSSI were actually from Elliot Lake.<sup>352</sup>

In any event, on reviewing the data and on the assumption that it was pertinent, GSSI concluded that the LifeLocator results were probably triggered by the presence of workers within the device’s exclusion zone. The company opined that the machine may have been picking up their movement and/or breathing despite the fact that Cst. Hulsman thought that he was operating the device in such a way as to avoid that possibility. The fact that the device was operated while suspended and oscillating did not appear to be problematic because GSSI was of the opinion that it could differentiate between that movement and the frequency given out by human breathing.



Commission counsel and Cst. Hulsman attempted to have GSSI attend the hearings to provide clarification and information on the operation and reliability of the device. GSSI declined to attend the hearings and, being an American company, was not compellable to attend.

Nevertheless, in correspondence with Commission counsel, the company commented:

The results show the certainty (not just a suspicion) that something was moving periodically 6 meters away and that after 50 seconds it started to move away from the sensor. Based on what we have been told, a logical inference is that the motion is caused by rescue workers in the area. NOTE: the results show several other objects moving slightly: one at a bit less than 5 meters.<sup>353</sup>

In the end, I am unable to reach any conclusion about the reliability of the device and whether the data it was analyzing came from a victim or was the result of improper usage, presence of persons within the recommended exclusion zone, or some other cause.

On March 5, 2014, GSSI provided additional submissions regarding the functionality and reliability of the device, as well as the training provided to the operators. These submissions were circulated to the Participants who were afforded an opportunity to respond. Submissions were received by the OPP, the Seniors' Action Group of Elliot Lake (SAGE), and the Ontario Association of Fire Chiefs. The additional submissions received from GSSI did not assist me in reaching any conclusions about the reliability of the device and the data put out by the device as to the identification of a victim.

## **Ontario Mine Rescue becomes aware of the collapse**

Alex Gryska with Ontario Mine Rescue testified that he only learned of the collapse upon his arrival at work on the Monday morning, June 25. Upon learning of the collapse, he met with the president and chief executive officer of Ontario Mine Rescue, Candys Ballanger-Michaud, to discuss whether they could assist Elliot Lake. They were both well aware that the Mall collapse was not their jurisdiction but they felt they needed to do something. A call was placed to the mayor's office to offer their services; however, they were unable to reach him. A call was also made to the Ministry of Labour. The offer of assistance was reported in the media. As I have explained elsewhere, their offer went unheeded.<sup>354</sup>

## Notes

- <sup>1</sup> Jeffreys testimony, October 3, 2013, pp. 28077–8.
- <sup>2</sup> Jeffreys testimony, October 3, 2013, p. 28078.
- <sup>3</sup> Jeffreys testimony, October 3, 2013, pp. 28079–80; Exhibit 9279, p. 70.
- <sup>4</sup> Jeffreys testimony, October 3, 2013, pp. 28079–80.
- <sup>5</sup> Jeffreys testimony, October 3, 2013, pp. 28081–2.
- <sup>6</sup> Exhibit 6226, p. 16; Exhibit 7924, p. 55; Jeffreys testimony, October 3, 2013, pp. 28090–1.
- <sup>7</sup> Jeffreys testimony, October 3, 2013, pp. 28085–6.
- <sup>8</sup> Jeffreys testimony, October 3, 2013, pp. 28086–7.
- <sup>9</sup> The photograph identified by Mr. Jeffreys is shown in the photograph with the yellow sign above the hand sanitizer dispenser. Exhibit 7924, p. 44; Hulsman testimony, August 28, 2013, p. 22928.
- <sup>10</sup> Jeffreys testimony, October 3, 2013, pp. 28087–9.
- <sup>11</sup> Jeffreys testimony, October 3, 2013, p. 28093.
- <sup>12</sup> Jeffreys testimony, October 3, 2013, p. 28093.
- <sup>13</sup> Gillespie testimony, September 3, 2013, p. 23559.
- <sup>14</sup> Gillespie testimony, September 3, 2013 pp. 23561–3; Thomas testimony, August 15, 2013, pp. 21094–5.
- <sup>15</sup> Gillespie testimony, September 3, 2013, pp. 23562–4.
- <sup>16</sup> Hulsman testimony, August 28, 2013, p. 22929.
- <sup>17</sup> Thomas testimony, August 15, 2013, pp. 21091–2.
- <sup>18</sup> Thomas testimony, August 20, 2013, pp. 21106–7; Officer testimony, August 21, 2013, p. 21668.
- <sup>19</sup> Thomas testimony, August 20, 2013, pp. 21106–8; Officer testimony, August 21, 2013, p. 21669.
- <sup>20</sup> Cox testimony, August 26, 2013, pp. 22309–10.
- <sup>21</sup> Cox testimony, August 26, 2013, p. 22311.
- <sup>22</sup> Burns testimony, August 20, 2013, pp. 21300–2; Exhibit 6404, p. 08.
- <sup>23</sup> Burns testimony, August 20, 2013, pp. 21300–8.
- <sup>24</sup> Waddick testimony, August 23, 2013, pp. 22090–3.
- <sup>25</sup> Waddick testimony, August 23, 2013, pp. 21993–5.
- <sup>26</sup> Waddick testimony, August 23, 2013, pp. 22098–9.
- <sup>27</sup> Officer testimony, August 29, 2013, pp. 23427–32.
- <sup>28</sup> Officer testimony, August 29, 2013, p. 23367.
- <sup>29</sup> Exhibit 6699; Chambers testimony, September 18, 2013, pp. 26134–6.
- <sup>30</sup> Cranford testimony, September 9, 2013, pp. 24741–3.
- <sup>31</sup> Cranford testimony, September 9, 2013, p. 24744.
- <sup>32</sup> Exhibit 6614, p. 57.
- <sup>33</sup> Comella testimony, September 9, 2013, pp. 24149–50.
- <sup>34</sup> Exhibit 6894, p. 02.
- <sup>35</sup> Neadles testimony, September 10, 2013, pp. 25307–8.
- <sup>36</sup> Neadles testimony, September 10, 2013, pp. 25308–9.
- <sup>37</sup> Comella testimony, September 4, 2013, pp. 24082–3.
- <sup>38</sup> Comella testimony, September 5, 2013, pp. 24145–8; Exhibit 6894.
- <sup>39</sup> Comella testimony, September 5, 2013, pp. 24153–4.
- <sup>40</sup> McCallion testimony, September 6, 2013, pp. 24495–7.
- <sup>41</sup> Jeffreys testimony, October 3, 2013, pp. 28111–3; Exhibit 6894.
- <sup>42</sup> Exhibit 6393, p. 58.
- <sup>43</sup> Comella testimony, September 4, 2013, p. 24075.
- <sup>44</sup> Comella testimony, September 4, 2013, p. 24076.
- <sup>45</sup> Comella testimony, September 4, 2013, p. 24081.
- <sup>46</sup> Thomas testimony, August 15, 2013, pp. 21096–97.
- <sup>47</sup> Chambers testimony, September 18, 2013, pp. 26136–8.
- <sup>48</sup> Chambers testimony, September 18, 2013, pp. 26246–47.
- <sup>49</sup> Officer testimony, August 21, 2013, p. 21672.
- <sup>50</sup> Officer testimony, August 21, 2013, pp. 21672–3.
- <sup>51</sup> Officer testimony, August 21, 2013, p. 21674.
- <sup>52</sup> Officer testimony, August 21, 2013, pp. 21674–7.
- <sup>53</sup> Gillespie testimony, September 3, 2013, p. 23581.
- <sup>54</sup> Officer testimony, August 21, 2013, p. 21677.
- <sup>55</sup> Officer testimony, August 21, 2013, pp. 21678–9.
- <sup>56</sup> Officer testimony, August 21, 2013, p. 21678.
- <sup>57</sup> Officer testimony, August 21, 2013, pp. 21687–8.
- <sup>58</sup> Officer testimony, August 22, 2013, p. 21742.
- <sup>59</sup> Officer testimony, August 22, 2013, p. 21744.
- <sup>60</sup> Officer testimony, August 22, 2013, pp. 21744–6.
- <sup>61</sup> Thomas testimony, August 15, 2013, pp. 21098–9.
- <sup>62</sup> Jeffreys testimony, October 3, 2013, p. 28105.
- <sup>63</sup> Jeffreys testimony, October 3, 2013, p. 28095.
- <sup>64</sup> Jones testimony, September 26, pp. 27400–4.
- <sup>65</sup> Exhibit 7643.
- <sup>66</sup> Jones testimony, September 26, 2013, pp. 27446–7.
- <sup>67</sup> Lacroix testimony, October 3, 2013, p. 28002; Exhibit 6385, p. 66.
- <sup>68</sup> Exhibit 6725.
- <sup>69</sup> Chambers testimony, September 18, 2013, pp. 26139–42.
- <sup>70</sup> Chambers testimony, September 18, 2013, pp. 26143–5.
- <sup>71</sup> Neadles testimony, September 10, 2013, pp. 25289–90.
- <sup>72</sup> Neadles testimony, September 10, 2013, pp. 25296–9.
- <sup>73</sup> Neadles testimony, September 10, 2013, pp. 25302–3.
- <sup>74</sup> Neadles testimony, September 10, 2013, pp. 25304–5.
- <sup>75</sup> Chambers testimony, September 18, 2013, pp. 26247–8.
- <sup>76</sup> Gillespie testimony, September 3, 2013, pp. 23587–9.
- <sup>77</sup> Gillespie testimony, September 3, 2013, pp. 23605–6 and 23611.
- <sup>78</sup> Gillespie testimony, September 3, 2013, pp. 23592–6.
- <sup>79</sup> Gillespie testimony, September 3, 2013, p. 25397.
- <sup>80</sup> McCallion testimony, September 6, 2013, pp. 24480–1.
- <sup>81</sup> Jeffreys testimony, October 3, 2013, p. 28094.
- <sup>82</sup> Exhibit 7924, p. 45.
- <sup>83</sup> Comella testimony, September 4, 2013, pp. 24087–97.
- <sup>84</sup> Comella testimony, September 4, 2013, pp. 24101–2.
- <sup>85</sup> Cranford testimony, September 9, 2013, pp. 24762–3.
- <sup>86</sup> Cranford testimony, September 9, 2013, pp. 24754–5; Exhibit 9279, p. 61.
- <sup>87</sup> Jeffreys testimony, October 3, 2013, pp. 28095–6.
- <sup>88</sup> Jeffreys testimony, October 3, 2013, p. 28096.
- <sup>89</sup> Jeffreys testimony, October 3, 2013, p. 28097.
- <sup>90</sup> Cranford testimony, September 9, 2013, pp. 24762–7.
- <sup>91</sup> Gillespie testimony, September 3, 2013, pp. 23566–7.
- <sup>92</sup> Jeffreys testimony, October 3, 2013, p. 28098.
- <sup>93</sup> Exhibit 7924, pp. 14, 17, 45.
- <sup>94</sup> Cranford testimony, September 9, 2013, pp. 24776–81.
- <sup>95</sup> Gillespie testimony, September 3, 2013, p. 23577.
- <sup>96</sup> Gillespie testimony, September 3, 2013, pp. 23578–80.
- <sup>97</sup> Gillespie testimony, September 3, 2013, pp. 23578–9.
- <sup>98</sup> Comella testimony, September 5, 2013, pp. 24113–4.
- <sup>99</sup> Gillespie testimony, September 3, 2013, p. 23579.
- <sup>100</sup> Guy Testimony, September 24, 2013, pp. 27077–8, 27101.
- <sup>101</sup> Glavin Testimony, October 1, 2013, pp. 27651, 27712.
- <sup>102</sup> McRae Testimony, September 25, 2013, pp. 27210–3.
- <sup>103</sup> Guy Testimony, September 24, 2013, p. 27082; Exhibit 7560.
- <sup>104</sup> Guy testimony, September 24, 2013, pp. 27083–5.
- <sup>105</sup> Guy testimony, September 24, 2013, pp. 27085–90.
- <sup>106</sup> Waddick testimony, August 23, 2013, p. 22004.

<sup>107</sup> Exhibit 6226, p. 23; Jeffreys testimony, October 3, 2013, pp. 28106–7.

<sup>108</sup> Jeffreys testimony, October 3, 2013, pp. 28106–7.

<sup>109</sup> Waddick testimony, August 23, 2013, pp. 21993–5.

<sup>110</sup> Comella testimony, September 5, 2013, pp. 24114–5.

<sup>111</sup> Comella testimony, September 5, 2013, p. 24115.

<sup>112</sup> Comella testimony, September 5, 2013, pp. 24116–17.

<sup>113</sup> Comella testimony, September 5, 2013, p. 24115.

<sup>114</sup> Comella testimony, September 5, 2013, p. 24117.

<sup>115</sup> Comella testimony, September 5, 2013, pp. 24121–2.

<sup>116</sup> Jeffreys testimony, October 3, 2013, pp. 28102–3.

<sup>117</sup> Comella testimony, September 5, 2013, pp. 24122–3.

<sup>118</sup> Officer testimony, August 21, 2013, pp. 21686, 21689.

<sup>119</sup> Comella testimony, September 5, 2013, pp. 24143–5.

<sup>120</sup> Comella testimony, September 5, 2013, pp. 24127.

<sup>121</sup> Comella testimony, September 5, 2013, pp. 24128–9.

<sup>122</sup> Comella testimony, September 5, 2013, p. 24131.

<sup>123</sup> Exhibit 7961.

<sup>124</sup> McCallion testimony, September 6, 2013, pp. 24491–3.

<sup>125</sup> McCallion testimony, September 6, 2013, pp. 24493–5.

<sup>126</sup> Comella testimony, September 5, 2013, pp. 24131–4; Exhibit 6393, p. 58.

<sup>127</sup> Comella testimony, September 5, 2013, p. 24135.

<sup>128</sup> Neadles testimony, September 10, 2013, pp. 25287–8.

<sup>129</sup> McCallion testimony, September 6, 2013, pp. 24489–91.

<sup>130</sup> Neadles testimony, September 10, 2013, pp. 25285–6.

<sup>131</sup> McCallion testimony, September 6, 2013, pp. 24503–5.

<sup>132</sup> McRae testimony, September 25, 2013, pp. 27216–9.

<sup>133</sup> Guy testimony, September 24, 2013, pp. 27097–103; Connors testimony, August 21, 2013, pp. 21428–9.

<sup>134</sup> Glavin testimony, October 1, 2013, pp. 27660–6.

<sup>135</sup> Priestly testimony, October 2, 2013, pp. 27803 and 27805–7; Exhibit 6622.

<sup>136</sup> Officer testimony, August 22, 2013, pp. 21703–4; Exhibit 3743, p. 16.

<sup>137</sup> Officer testimony, August 22, 2013, pp. 21704–5.

<sup>138</sup> Officer testimony, August 22, 2013, pp. 21705–11; Exhibit 3743 pp.17–18.

<sup>139</sup> Officer testimony, August 22, 2013; pp. 21701–2; Exhibit 3743, p.18.

<sup>140</sup> deBortoli testimony, October 7, 2013, pp. 28437–8; Exhibit 3743, p.19.

<sup>141</sup> Jollymore testimony, September 24, 2013, pp. 26888–90.

<sup>142</sup> Neadles testimony, September 10, 2013, p. 25310.

<sup>143</sup> Neadles testimony, September 10, 2013, pp. 25311–12.

<sup>144</sup> Comella testimony, September 4, 2013, pp. 24078–80.

<sup>145</sup> Selvers testimony, September 9, 2013, pp. 25018–19; Exhibit 6246, p. 03.

<sup>146</sup> Selvers testimony, September 9, 2013, pp. 25019–21.

<sup>147</sup> Selvers testimony, September 9, 2013, pp. 25021–2; Exhibit 6246, p. 03.

<sup>148</sup> Selvers testimony, September 9, 2013, p. 25023.

<sup>149</sup> Selvers testimony, September 9, 2013, p. 25023; Selvers testimony, September 10, 2013, pp. 25165–6.

<sup>150</sup> Selvers testimony, September 9, 2013, pp. 25023–5.

<sup>151</sup> Selvers testimony, September 10, 2013, pp. 25166–7; Exhibit 6246, p. 06.

<sup>152</sup> Comella testimony, September 5, 2013, pp. 24210–11.

<sup>153</sup> Selvers testimony, September 10, 2013, p. 25176.

<sup>154</sup> Neadles testimony, September 11, 2013, pp. 25335–6.

<sup>155</sup> Comella testimony, September 5, 2013, pp. 24166–7.

<sup>156</sup> Neadles testimony, September 11, 2013, pp. 25336–7.

<sup>157</sup> Exhibit 6610.

<sup>158</sup> Hamilton testimony, October 7, 2013, pp. 28514–15.

<sup>159</sup> deBortoli testimony, October 7, 2013, pp. 28424–6.

<sup>160</sup> Hamilton testimony, October 7, 2013, p. 28515; deBortoli testimony, October 7, 2013, p. 28426.

<sup>161</sup> Chambers testimony, September 18, 2013, pp. 26145–6; Exhibit 6766.

<sup>162</sup> Chambers testimony, September 18, 2013, pp. 26146–9.

<sup>163</sup> Fowlds testimony, September 19, 2013, pp. 26314–16, 26319.

<sup>164</sup> Neadles testimony, September 11, 2013, pp. 25328–31; Exhibit 6894, pp. 01–02.

<sup>165</sup> Neadles testimony, September 11, 2013, pp. 25328–9.

<sup>166</sup> McGuinty testimony, October 9, 2013, pp. 28902–3; Exhibit 6630.

<sup>167</sup> Exhibit 6632.

<sup>168</sup> McGuinty testimony, October 9, 2013, pp. 28905–6.

<sup>169</sup> Officer testimony, August 22, 2013, p. 21728; Exhibit 3743, p. 20.

<sup>170</sup> Officer testimony, August 22, 2013, p. 21728, Exhibit 3743, p. 21.

<sup>171</sup> Exhibit 3743, p. 22.

<sup>172</sup> Officer testimony, August 22, 2013, p. 21729.

<sup>173</sup> Exhibit 3743, p. 20.

<sup>174</sup> Fowlds testimony, September 19, 2013, pp. 26329–34; Exhibit 7924, pp. 15, 46–7.

<sup>175</sup> Fowlds testimony, September 19, 2013, pp. 26334–5.

<sup>176</sup> Exhibit 6894, p. 01.

<sup>177</sup> Neadles testimony, September 11, 2013, pp. 25332–3.

<sup>178</sup> Neadles testimony, September 11, 2013, p. 25338.

<sup>179</sup> Exhibit 6894, p. 01.

<sup>180</sup> Comella testimony, September 5, 2013, p. 24167.

<sup>181</sup> Neadles testimony, September 11, 2013, p. 25338.

<sup>182</sup> McCallion testimony, September 6, 2013, pp. 24511–12.

<sup>183</sup> Exhibit 8109, p. 015.

<sup>184</sup> Officer testimony, August 22, 2013, pp. 21729–30.

<sup>185</sup> Officer testimony, September 19, 2013, p. 26409.

<sup>186</sup> Bruce testimony, August 23, 2013, pp. 22191–2.

<sup>187</sup> Officer testimony, August 22, 2013, pp. 21733–4; Exhibit 6336, p. 61.

<sup>188</sup> Officer testimony, August 22, 2013, pp. 21734–5.

<sup>189</sup> deBortoli testimony, October 7, 2013, p. 28426.

<sup>190</sup> deBortoli testimony, October 7, 2013, p. 28431.

<sup>191</sup> Cranford testimony, September 9, pp. 24770–1.

<sup>192</sup> Comella testimony, September 5, 2013, pp. 24170–4.

<sup>193</sup> Cranford testimony, September 9, 2013, pp. 24865–77; Exhibit 9582, p. 02.

<sup>194</sup> Cranford testimony, September 9, 2013, p. 24878.

<sup>195</sup> McCallion testimony, September 6, 2013, pp. 24516–18.

<sup>196</sup> Neadles testimony, September 11, 2013, pp. 25361–4.

<sup>197</sup> Exhibit 6894, p. 51.

<sup>198</sup> Neadles testimony, September 11, 2013, p. 25343.

<sup>199</sup> Neadles testimony, September 11, 2013, pp. 25343–4.

<sup>200</sup> Comella testimony, September 5, 2013, pp. 24175–6.

<sup>201</sup> Cranford testimony, September 9, 2013, p. 24772.

<sup>202</sup> Exhibit 7961; Exhibit 7959.

<sup>203</sup> Neadles testimony, September 11, 2013, pp. 25345–7.

<sup>204</sup> Selvers testimony, September 10, 2013, pp. 25272–3.

<sup>205</sup> Exhibit 6894, p. 51.

<sup>206</sup> McCallion testimony, September 6, 2013, pp. 24514–15.

<sup>207</sup> Selvers testimony, September 9, 2013, p. 25027; Exhibit 6246, p. 04.

<sup>208</sup> Selvers testimony, September 9, 2013, pp. 25027–8.



- <sup>209</sup> Exhibit 7924, p. 103.
- <sup>210</sup> Selvers testimony, September 9, 2013, pp. 25028–30.
- <sup>211</sup> Selvers testimony, September 9, 2013, pp. 25030–2.
- <sup>212</sup> Selvers testimony, September 9, 2013, pp. 25038–9 and 25051; Exhibit 6246, p. 05.
- <sup>213</sup> Selvers testimony, September 10, 2013, pp. 25052–4.
- <sup>214</sup> Selvers testimony, September 10, 2013, pp. 25054–5.
- <sup>215</sup> Selvers testimony, September 10, 2013, pp. 25061–3.
- <sup>216</sup> Cranford testimony, September 9, 2013, p. 24772.
- <sup>217</sup> Officer testimony, August 22, 2013, pp. 21747, 21749; Exhibit 3743, p. 23.
- <sup>218</sup> Officer testimony, August 22, 2013, pp. 21750–1.
- <sup>219</sup> Exhibit 3743, p. 25.
- <sup>220</sup> Officer testimony, August 22, 2013, p. 21753.
- <sup>221</sup> Neadles testimony, September 11, 2013, p. 25350.
- <sup>222</sup> Neadles testimony, September 11, 2013, pp. 25353–5; Exhibit 3743, p. 024.
- <sup>223</sup> Jollymore testimony, September 24, 2013, pp. 26903–4.
- <sup>224</sup> Exhibit 6609.
- <sup>225</sup> Gillespie testimony, September 3, 2013, pp. 23597–8.
- <sup>226</sup> Gillespie testimony, September 3, 2013, pp. 23601–2.
- <sup>227</sup> Exhibit 7844, p. 45.
- <sup>228</sup> Exhibit 7844, p. 45.
- <sup>229</sup> Gillespie testimony, September 3, 2013, pp. 23602–5.
- <sup>230</sup> Waddick testimony, August 23, 2013, pp. 22001–3; Exhibit 6378, pp. 007–8; Exhibit 6379, p. 001; Exhibit 7010, pp. 001–2.
- <sup>231</sup> Cox testimony, August 26, 2013, pp. 22321–2.
- <sup>232</sup> Cox testimony, August 26, 2013, pp. 22323–4.
- <sup>233</sup> Hulsman testimony, August 28, 2013, pp. 22934–8.
- <sup>234</sup> Hulsman testimony, August 28, 2013, pp. 22943–6.
- <sup>235</sup> Glavin testimony, October 1, 2013, pp. 27666–8.
- <sup>236</sup> Sorel testimony, October 1, 2013, p. 27553.
- <sup>237</sup> Sorel testimony, October 1, 2013, pp. 27560–3.
- <sup>238</sup> Officer testimony, August 22, 2013, pp. 21754–5; Exhibit 6336, p. 73.
- <sup>239</sup> Officer testimony, August 22, 2013, pp. 21755–6.
- <sup>240</sup> Comella testimony, September 5, 2013, pp. 24178–9.
- <sup>241</sup> Exhibit 6378, p. 08.
- <sup>242</sup> Gillespie testimony, September 3, 2013, pp. 23612–15; Exhibits 6378, p. 08; Exhibit 7924, pp. 53–5.
- <sup>243</sup> Gillespie testimony, September 3, 2013, pp. 23615–16, 23618–22; Exhibit 6378, pp. 008–010.
- <sup>244</sup> Cranford testimony, September 9, 2013, p. 24776; Exhibit 7545.
- <sup>245</sup> McCallion testimony, September 6, 2013, pp. 24524–6; Exhibit 6342, p. 22.
- <sup>246</sup> Exhibit 6894, p. 51.
- <sup>247</sup> Neadles testimony, September 11, 2013, p. 25360.
- <sup>248</sup> Gillespie testimony, September 3, 2013, p. 23623.
- <sup>249</sup> Selvers testimony, September 10, 2013, pp. 25048–51, 25056–61; Exhibit 6246, p. 06.
- <sup>250</sup> Selvers testimony, September 10, 2013, pp. 25063–5; Exhibit 6246, p. 05.
- <sup>251</sup> Selvers testimony, September 10, 2013, pp. 25067–8; Exhibit 6407.
- <sup>252</sup> Selvers testimony, September 10, 2013, pp. 25068–70; Exhibit 7828.
- <sup>253</sup> Cox testimony, August 26, 2013, p. 22326.
- <sup>254</sup> Selvers testimony, September 10, 2013, pp. 25070–1; Exhibit 7829.
- <sup>255</sup> Comella testimony, September 5, 2013, pp. 24182–4.
- <sup>256</sup> Sanders testimony, October 4, 2013, pp. 28280–2.
- <sup>257</sup> Selvers testimony, September 10, 2013, p. 25074; Exhibit 7924, p. 48.
- <sup>258</sup> Neadles testimony, September 11, 2013, pp. 25364–5; Exhibit 6924.
- <sup>259</sup> Bailey testimony, August 27, 2013, pp. 22734–6, 22743–8.
- <sup>260</sup> Neadles testimony, September 11, 2013, pp. 25365–7; Exhibit 3743, p. 26.
- <sup>261</sup> Comella testimony, September 5, 2013, pp. 24184–5; Exhibit 7946; Exhibit 6393, p. 62.
- <sup>262</sup> Comella testimony, September 5, 2013, pp. 24185, 24189–91.
- <sup>263</sup> Exhibit 6393, p. 62.
- <sup>264</sup> Comella testimony, September 5, 2013, pp. 24192–8; Exhibit 7924, p. 53.
- <sup>265</sup> Hulsman testimony, August 28, 2013, p. 23009.
- <sup>266</sup> Hulsman testimony, August 28, 2013, p. 22999.
- <sup>267</sup> Hulsman testimony, August 28, 2013, p. 23008.
- <sup>268</sup> Hulsman testimony, August 28, 2013, pp. 23001–2.
- <sup>269</sup> Hulsman testimony, August 28, 2013, pp. 23018–20.
- <sup>270</sup> Gillespie testimony, September 3, 2013, pp. 23635–6, 23644–7; Exhibit 6378, pp. 14–15.
- <sup>271</sup> Gillespie testimony, September 3, 2013, p. 23628.
- <sup>272</sup> Exhibit 6378, pp. 14–15.
- <sup>273</sup> Exhibit 6379.
- <sup>274</sup> Sorel testimony, October 1, 2013, pp. 27565–6.
- <sup>275</sup> Selvers testimony, September 10, 2013, pp. 25078–9.
- <sup>276</sup> Exhibit 7924, p. 47.
- <sup>277</sup> Cranford testimony, September 9, 2013, pp. 24794–6; Exhibit 7545.
- <sup>278</sup> Cranford testimony, September 9, 2013, pp. 24796–7.
- <sup>279</sup> Glavin testimony, October 1, 2013, pp. 27708–9; Exhibit 7617, p. 90.
- <sup>280</sup> Sorel testimony, October 1, 2013, p. 27573.
- <sup>281</sup> Waddick testimony, August 23, 2013, pp. 22005–9.
- <sup>282</sup> Waddick testimony, August 23, 2013, pp. 22009–10.
- <sup>283</sup> Waddick testimony, August 23, 2013, pp. 22012–16.
- <sup>284</sup> Waddick testimony, August 23, 2013, pp. 22017–19.
- <sup>285</sup> Gillespie testimony, September 3, 2013, pp. 23648–9.
- <sup>286</sup> Gillespie testimony, September 3, 2013, pp. 23651–5; Exhibit 6378, pp. 015–16; Exhibit 6393, pp. 63–4.
- <sup>287</sup> Sorel testimony, October 1, 2013, p. 27581.
- <sup>288</sup> Sorel testimony, October 1, 2013, p. 27581.
- <sup>289</sup> Comella testimony, September 5, 2013, pp. 24340–2; Exhibit 6393, p. 63.
- <sup>290</sup> Comella testimony, September 5, 2013, pp. 24342–4.
- <sup>291</sup> Glavin testimony, October 1, 2013, pp. 27688–9.
- <sup>292</sup> Hulsman testimony, August 28, 2013, pp. 22947–53.
- <sup>293</sup> Kerr testimony, September 25, 2013, pp. 27311–12.
- <sup>294</sup> Exhibit 6402.
- <sup>295</sup> Kerr testimony, September 25, 2013, pp. 27313–14.
- <sup>296</sup> Jollymore testimony, September 24, 2013, pp. 27024–5.
- <sup>297</sup> Gendron testimony, August 8, 2013, pp. 20027–34; Aylwin testimony (Mr. and Mrs.), August 7, 2013, p. 19976.
- <sup>298</sup> Kerr testimony, September 25, 2013, pp. 27314–15.
- <sup>299</sup> Latulippe and Perizzolo testimony, August 7, 2013, pp. 19898–901.
- <sup>300</sup> Kerr testimony, September 25, 2013, pp. 27318, 27322.
- <sup>301</sup> Kerr testimony, September 25, 2013, pp. 27323–4; Exhibit 6402.
- <sup>302</sup> Kerr testimony, September 25, 2013, p. 27324.
- <sup>303</sup> Kerr testimony, September 25, 2013, p. 27325.
- <sup>304</sup> Jollymore testimony, September 24, 2013, p. 26895.
- <sup>305</sup> Jollymore testimony, September 24, 2013, pp. 26895–7.

- <sup>306</sup> Jollymore testimony, September 24, 2013, pp. 26907–8.
- <sup>307</sup> Jollymore testimony, September 24, 2013, pp. 26911–13.
- <sup>308</sup> Jollymore testimony, September 24, 2013, pp. 26994–5.
- <sup>309</sup> Comella testimony, September 5, 2013, p. 24340; Exhibit 6393, p. 63.
- <sup>310</sup> Exhibit 7477, p. 61.
- <sup>311</sup> Feldman testimony, September 18, 2013, p. 26023; Exhibit 9634, p. 72.
- <sup>312</sup> Cranford testimony, September 9, 2013, pp. 24798–800; Exhibit 7545.
- <sup>313</sup> Gillespie testimony, September 3, 2013, pp. 23663–4; Exhibit 6378, p. 16.
- <sup>314</sup> Gillespie testimony, September 3, 2013, pp. 23669–70; Exhibit 6378, pp. 17–18.
- <sup>315</sup> Comella testimony, September 5, 2013, pp. 24224–5.
- <sup>316</sup> Fowlds testimony, September 19, 2013, pp. 26341–7.
- <sup>317</sup> Bailey testimony, August 27, 2013, pp. 22756 and 22760; Exhibit 6374, p. 03.
- <sup>318</sup> McCallion testimony, September 6, 2013, pp. 24534–40; Exhibit 6342, p. 23.
- <sup>319</sup> Gillespie testimony, September 3, 2013, pp. 23664–5, 23668; Exhibit 6378, pp. 16–17.
- <sup>320</sup> Hulsman testimony, August 28, 2013, pp. 23032–6.
- <sup>321</sup> Glavin testimony, October 1, 2013, p. 27694.
- <sup>322</sup> Glavin testimony, October 1, 2013, p. 27704.
- <sup>323</sup> Glavin testimony, October 1, 2013, p. 27701–2.
- <sup>324</sup> Glavin testimony, October 1, 2013, pp. 27703–6.
- <sup>325</sup> Gillespie testimony, September 3, 2013, pp. 23666–8; Exhibit 6378, p. 17.
- <sup>326</sup> McCallion testimony, September 6, 2013, pp. 24542–5, 24551.
- <sup>327</sup> McCallion testimony, September 6, 2013, pp. 24546–7.
- <sup>328</sup> McCallion testimony, September 6, 2013, pp. 24544–5.
- <sup>329</sup> McCallion testimony, September 6, 2013, pp. 24564–5.
- <sup>330</sup> Gillespie testimony, September 3, 2013, pp. 23670–2, 23679; Exhibit 6378, pp. 18–19.
- <sup>331</sup> Gillespie testimony, September 3, 2013, pp. 23673–5; Exhibit 6378, pp. 18–19.
- <sup>332</sup> McCallion testimony, September 6, 2013, pp. 24709–10.
- <sup>333</sup> Jones testimony, September 26, 2013, pp. 27390–2.
- <sup>334</sup> Gillespie testimony, September 3, 2013, pp. 23684–5.
- <sup>335</sup> Comella testimony, September 5, 2013, p. 24198.
- <sup>336</sup> Comella testimony, September 5, 2013, p. 24202; Exhibit 7924, p. 46.
- <sup>337</sup> Neadles testimony, September 11, 2013, pp. 25383–4.
- <sup>338</sup> Gillespie testimony, September 3, 2013, pp. 23680–4.
- <sup>339</sup> Cox testimony, August 26, 2013, pp. 22371–4; Exhibit 6377, p. 07.
- <sup>340</sup> Gillespie testimony, September 3, 2013, p. 23689; Exhibit 6378, pp. 19–20.
- <sup>341</sup> Exhibit 3743, p. 29.
- <sup>342</sup> Exhibit 3743, p. 30.
- <sup>343</sup> Neadles testimony, September 11, 2013, pp. 25389–92.
- <sup>344</sup> Exhibit 3743, p. 31.
- <sup>345</sup> Hulsman testimony, August 28, 2013, p. 22999.
- <sup>346</sup> Hulsman testimony, August 28, 2013, pp. 22956–7.
- <sup>347</sup> Hulsman testimony, August 28, 2013, pp. 22959–60; Exhibit 9224.
- <sup>348</sup> Hulsman testimony, August 28, 2013, pp. 22964–8, 22970.
- <sup>349</sup> Hulsman testimony, August 28, 2013, pp. 22973–4, 22977–9, 22985–6.
- <sup>350</sup> Gillespie testimony, September 3, 2013, pp. 23641–3.
- <sup>351</sup> Hulsman testimony, August 28, 2013, pp. 23038–40.
- <sup>352</sup> Hulsman testimony, August 28, 2013, pp. 22992–5, 22997.
- <sup>353</sup> Exhibit 9210, p. 04.
- <sup>354</sup> Gryska testimony, September 23, 2013, pp. 26691–2; Exhibit 9737.

## Calling Off the Rescue: Now Recovery (9:30 a.m. to 7:30 p.m. on June 25)

<b>9:30 a.m.: Devices are made to measure the movement of the structure .....</b>	<b>165</b>
<b>10 a.m.: Workers are ordered off site until engineering assessment complete .....</b>	<b>166</b>
<b>10:45 a.m. – 11 a.m.: Staff Insp. William Neadles and Community Control Group are advised of work stoppage .....</b>	<b>166</b>
<b>10:54 a.m.: Dr. Michael Feldman advises HUSAR/TF3 leadership they cannot assume any trapped victims have died until 27 more hours have passed .....</b>	<b>167</b>
<b>Noon: The device shows movement, and Capt. Comella decides to have rescuers removed from the site without waiting for Mr. Cranford's engineering assessment .....</b>	<b>170</b>
<b>12:05 p.m.: Press conference – public advised that the situation is dangerous, but still signs of life and new approach being taken .....</b>	<b>171</b>
<b>Early afternoon: Decision is made to cease all operations. ....</b>	<b>173</b>
<b>1:30 p.m.: Mr. Cranford determines a beam is significantly overloaded and can, with significant problems, be partially supported by wood shores .....</b>	<b>173</b>
<b>Before 2 p.m.: Staff Insp. Neadles orders that all responders be withdrawn from the building .</b>	<b>174</b>
Staff Insp. Neadles's evidence: his decision, based on meeting with Cmdr. McCallion, Capt. Comella, Mr. Cranford, and Mr. Jeffreys .....	174
Fire Chief Paul Officer's evidence: decision made by unified command at a meeting with S taff Insp. Neadles, Cmdr. McCallion, Capt. Comella, Mr. Jeffreys, and Bob Thorpe; MOL to order site closed .....	175
Mr. Jeffreys's and MOL witnesses' evidence: no such meeting, no such order .....	176
Cmdr. McCallion's evidence: initial decision based on Capt. Comella's recommendation, confirmed by Staff Insp. Neadles, before hearing from the engineers; subsequent decision made by Staff Insp. Neadles, with no input from the engineers .....	177
Mr. Cranford's evidence: his calculations discussed with Capt. Comella, Mr. Jeffreys, Mr. Sanders, and Sgt. Gillespie; no discussion with or advice directly to Staff Insp. Neadles or Cmdr. McCallion .....	178
Capt. Comella's evidence: no recollection of decision to remove teams from the pile, or of speaking to Staff Insp. Neadles, Sgt. Gillespie, Mr. Cranford, Mr. Jeffreys, or Cmdr. McCallion about it; he was waiting for decision .....	179
Sgt. Gillespie is told that no workers will be allowed in the building, even if signs of life continue .....	180



Mr. Sorel is told to return to Toronto .....	180
Conclusions about decisions between 1:20 p.m. and 2 p.m. ....	181
<b>Families are spoken to inappropriately by Insp. Percy Jollymore .....</b>	<b>183</b>
2 p.m.: Fire Department and HUSAR/TF3 are told building completely unsafe and no options available .....	184
Shortly after 2 p.m.: Rescue changes to a recovery – the team sees no options (and none are sought) .....	185
<b>2:20 p.m.: HUSAR/TF3 members engage in “make-work” .....</b>	<b>188</b>
<b>2:30 p.m.: Mr. Cranford determines that stabilization may be possible but does not tell HUSAR/TF3 .....</b>	<b>188</b>
<b>Conclusion: Decision to stop the rescue is made without further consultation with Mr. Cranford or Mr. Jeffreys .....</b>	<b>190</b>
<b>3 p.m. CCG meeting .....</b>	<b>190</b>
Staff Insp. Neadles announces the rescue is over. ....	190
Staff Insp. Neadles makes a poor choice to attend the CCG meeting .....	191
Serious confusion about the MOL’s role and actions .....	192
<b>The decision to stop the rescue is communicated .....</b>	<b>194</b>
To the families – in a less-than-sensitive manner. ....	194
To the OPP UCRT members – with an expression of frustration. ....	196
To the public – the 5 p.m. press conference .....	196
<b>The community reacts with frustration .....</b>	<b>198</b>
<b>After the cancellation of the rescue, options appear limited .....</b>	<b>200</b>
<b>Sgt. Phil Glavin raises with Staff Insp. Neadles the prospect of using Priestly. ....</b>	<b>201</b>
<b>HUSAR/TF3 prepares to leave .....</b>	<b>202</b>
Staff Insp. Neadles tells his members they are going home .....	202
Key personnel are sent packing. ....	202
MPP Michael Mantha threatens to chain himself to the HUSAR/TF3 bus. ....	203
<b>Notes .....</b>	<b>204</b>

The morning of June 25 brought with it increased concern for the safety of the workers in the “hot zone.” The building showed ominous signs of potentially imminent collapse. This led to a series of decisions which, by mid-afternoon, resulted in the rescue being called off. In this chapter, I explain how those decisions were made and highlight some things that could have been done differently. I note, in particular, that if more attention had been paid to planning the emergency response, the decision to abandon the rescue might not have been made so quickly, and might have been a decision to merely retreat, regroup, and reassess.

## 9:30 a.m.: Devices are made to measure the movement of the structure

James Cranford, engineer with HUSAR/TF3, testified that, when he returned to the site at about 9:30 a.m. on June 25, he spoke to Capt. Tony Comella, the team leader, who wanted him to determine, as they had discussed the previous evening, how much stress was on the beams supporting the escalator and whether they could be shored from below. Capt. Comella asked if it would be useful to know if the building was moving. Mr. Cranford agreed and thought it would be ideal if any movement could be confirmed by some sort of measurement device. They did not have a more detailed discussion, and Mr. Cranford gave no specific advice about how to construct a measuring device. He did tell Capt. Comella that it would be helpful to know if the top of the escalator was moving.<sup>1</sup>

Capt. Comella arranged for measuring devices to be made. One device consisted of simple blocks of wood, one resting on the floor tile immediately next to the top of the escalator and the other resting on the steel plate at the top of the escalator. They were built flush with each other. If there was movement, it would be shown by a height differential between the pieces of wood. The blocks were not glued or attached to the floor or the plate.<sup>2</sup> The other device was installed on the ground floor, on the south side of the escalator (the opposite side from the rubble pile). It consisted of two posts, one extending from the ground up and the other extending down from the beam supporting the escalator. The two posts came in contact with each other, and a board behind them had lines marked in one-inch increments. If the beam moved vertically, the relative positions of the two posts changed.<sup>3</sup>

Although Mr. Cranford had advised Capt. Comella that it would be useful to install a measuring device, his examination of the device at the top of the stairs (the only device he testified he knew of) was from a distance of 50 or 60 feet. He did not know whether the blocks of wood had been flush when it was installed, and so he could not tell if the device showed any movement between the time of installation and his later observation.<sup>4</sup>

He recalled being asked about the effect of movement on the structure, and that he had advised that movement, in general, was a warning sign. If there was ongoing movement, it was an especially strong warning sign. By the morning of June 25, no additional loads were being applied to the structure, so any movement was caused by the existing load and meant that the steel within the structure had exceeded its capacity and started to fail. The deflection, or movement, of the beam was a warning sign. At some point the steel would fail and, depending on where the failure occurred, it could be catastrophic and sudden. He testified that it was impossible to predict when the failure would occur. He recalled giving this advice, but not to whom he gave it, other than to say that he did not recall speaking to Roger Jeffreys, provincial engineer with the Ministry of Labour (MOL).<sup>5</sup>

**By the morning of June 25, no additional loads were being applied to the structure, so any movement was caused by the existing load and meant that the steel within the structure had exceeded its capacity and started to fail.**

## 10 a.m.: Workers are ordered off site until engineering assessment complete

At 10 a.m., Sgt. Jamie Gillespie of the OPP UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear and Explosive Response Team) met with Capt. Comella and Cmdr. Michael McCallion, site commander, HUSAR/TF3, after the UCRT and HUSAR/TF3 members had left the rubble pile. Capt. Comella and Cmdr. McCallion told him that they would not allow any workers to return to the rubble pile until an engineering assessment had been done of the continued movement of the building and its effect on the workers' safety. Sgt. Gillespie's notes state: "I told them that will not leave unless they promised me to put full day resources at gaining access to viable person. Promise of this given by both Comella and McCallion." He testified that this reflected

utter defeat. We had come very close to successfully accessing the person and we had to stop, and it was very hard to deal with. So, I basically just asked them to make sure they put everything they had towards getting to that person.<sup>6</sup>

Sgt. Gillespie testified that this decision was imposed on him by Capt. Comella and Cmdr. McCallion. He was emotional about the decision and told his men at the briefing at 5 p.m. that day that he had heatedly objected to it. He testified that it was a hard decision because he was caught between wanting to get to the trapped person as quickly as possible and weighing that against the danger to the team.<sup>7</sup>

Cmdr. McCallion recalled this discussion and had recorded it in his notebook, at 10:30 a.m., which he testified was the time he had written it:

Call from Comella to see him with OPPTL [OPP team leader] on 3rd floor roof. Met and advised the escalator section is moving away from the building ... Concerns the instability of the site is increasing. Comella to meet with MOL/HUSAR engineer to discuss. Measurements to be obtained.<sup>8</sup>

Cmdr. McCallion believed that Capt. Comella had called the work stoppage because of what he suspected was happening to the building. He also recalled that Sgt. Gillespie wanted assurances that the operation was going to be continued. At that time, no device had been installed to measure the movement of the beam supporting the escalator and the concrete piled on top of it.<sup>9</sup>

Don Sorel of HUSAR/TF3 testified that he and the other riggers were pulled out between 9 and 10 a.m. on orders from Cmdr. McCallion and the rigging operations came to a halt. He did not understand that operations were stopped at that time – he thought that "they wanted to have a second look and we needed a rest." He recalled that, when he received these orders, it was as part of a conversation involving him, Cmdr. McCallion, Sgt. Gillespie, OPP Cst. Patrick Waddick, and OPP Cst. Ryan Cox. The OPP personnel were lobbying to stay longer.<sup>10</sup>

## 10:45 a.m. – 11 a.m.: Staff Insp. William Neadles and Community Control Group are advised of work stoppage

Cmdr. McCallion testified that he called Staff Insp. William Neadles, site commander. He was asked if Staff Insp. Neadles had said, in response, "Pull the guys out." He did not recall receiving those instructions. His notes record the following at 10:45 a.m., immediately after the discussion between him, Capt. Comella, and Sgt. Gillespie:

B. Neadles advised of situation. Possibility of having to stop OPS [operations] if instability increases.<sup>11</sup>



This evidence is consistent with that of Elliot Lake Fire Chief Paul Officer, who had made an entry in his notes compiled after the event, that at approximately 10:55 a.m. "HUSAR IC updated on rescue, advises the escalator 'still shifting.'"<sup>12</sup> This note does not appear in the notes made by his scribe, Natalie Quinn, so the timing is not precise. Chief Officer testified that this note referred to a conversation he had with Staff Insp. Neadles before the Community Control Group (CCG) meeting to discuss the press conference. When specifically asked, he could not recall whether he was told at that time, or at the CCG shortly after, that personnel had been pulled out.<sup>13</sup>

Staff Insp. Neadles testified that he spoke to Cmdr. McCallion while he was on his way to a meeting of the CCG to prepare for the scheduled noon press conference. He recalled that Cmdr. McCallion told him that they had seen some minor movement. He initially testified that he had not been told that operations had in fact stopped. He was then shown the notes taken during the CCG meeting which started at 11:06 a.m. and recorded:

HUSR [sic] – Pulled person[n]el out – need to reassess – escalator unstable – to support escalator estimate 2 days – can not work ard [around] Escalator – to go in the north end – based on still on rescue due to sonar hit this am.<sup>14</sup>

Staff Insp. Neadles then recalled he had relayed to the CCG what Cmdr. McCallion had told him (and not information obtained from another source after he spoke with Cmdr. McCallion), but he could not recall if he had been told that some people had actually been removed from the site.<sup>15</sup>

Clearly the group had been told that some personnel had been pulled out, that it was unsafe to work around the escalator, and that the operation was still being seen as a rescue as a result of the positive LifeLocator signal received at 5:30 a.m. that day. The evidence of Sgt. Gillespie and Cmdr. McCallion confirms that a work stoppage had been ordered. I conclude that this information was passed to Staff Insp. Neadles by Cmdr. McCallion in the 10:45 a.m. phone call.

## 10:54 a.m.: Dr. Michael Feldman advises HUSAR/TF3 leadership they cannot assume any trapped victims have died until 27 more hours have passed

At 10:54 a.m., Dr. Michael Feldman, the HUSAR/TF3 team doctor, sent an email to Capt. Comella and Cmdr. McCallion, asking them to share it with Staff Insp. Neadles, whose email address he did not have:

A rule of thumb is that a trapped person can survive 3 days without water. However, a resourceful, uninjured person trapped with some supplies (e.g. a food court) can survive much longer.

I doubt anyone in that rubble is uninjured, and although the puddles indicate there may be access to rainwater/spilled water/drinks present in the food court. Also, I am advised by the local emergency physician that one of the people suspected by local medical authorities to be in the collapse is diabetic and is less likely to survive due to dehydration.

**If there are no more Delsar indications/sounds/signs of life detected 72 hours after the collapse (tomorrow afternoon), it will be acceptable medically to consider this a body recovery operation after that point.**

...

Any communication with the public or media should **acknowledge there are rare exceptions ("miracles")** to the 3 day rule of thumb and that we remain prepared to find and treat patients.

Hope this helps with planning.<sup>16</sup> [Emphasis in original.]

Dr. Feldman testified that this opinion was based on his knowledge as an emergency room physician, his training at the disaster medical specialist course, his reading of some of the literature about the kinds of things that one may encounter, and his inspection of the rubble pile. He sent it in order to provide information he thought the team might need for planning. He had not been asked by anybody to provide such an opinion.<sup>17</sup>

The reference in the email to “Delsar indications” referred to a device consisting of microphones and amplification equipment that he understood the HUSAR/TF3 team would be using to listen for sounds of life. He was aware at the time he sent the email that the team was using listening devices and that they believed they had heard sounds from the rubble pile.<sup>18</sup>

Cmdr. McCallion testified that he sent this email to Staff Insp. Neadles on June 25, but, although they did discuss the likelihood of anyone being alive, they did not have discussions “specific to the email.” Cmdr. McCallion is a paramedic. He testified that he thought the chances of someone surviving were very remote, based on the evidence of the structural collapse, the state of the pile, the compacting of the different slabs, and his own medical opinion.<sup>19</sup> I note that Dr. Feldman had seen the site and the state of the pile as well.<sup>20</sup>

Staff Insp. Neadles testified that he received Dr. Feldman’s email sometime later on June 25. He also testified that he had a face-to-face conversation with Dr. Feldman on Sunday afternoon or Monday morning in the tent, during which the doctor told him that he did not believe that there was anyone alive. He testified:

he [Dr. Feldman] didn’t believe that there was much viability going forward of any of the victims surviving ...

...

He really felt that there was no chance of anyone surviving that, and that even if they had survived the initial, that if they were crushed under that rubble, that even once you pulled the rubble off, it would be a very slim chance of survival after that even then.<sup>21</sup>

Staff Insp. Neadles was asked if it was safe to assume that, prior to the rescue being called off, he would have read Dr. Feldman’s email. He replied, “Whether I would have read the entire thing, I would like to think I did, but I can’t guarantee that I did.” It was his evidence that he did not speak to Dr. Feldman to tell him about the LifeLocator soundings, and he did not know if anyone else had done so. He also testified that:

I knew in my head that this was going to be a very difficult situation for anyone to survive, but my heart was telling me that I still need to go forward with continuing this and not just saying this is – I have no medical proof. I have no medical background other than to go with what the doctor has told me [that there was no chance of anyone surviving] and – but I’m still moving forward to say that I do believe that there was a viable sign of life at 04:00, and that is the last I can go from that.<sup>22</sup>

Dr. Feldman’s evidence contradicted Staff Insp. Neadles. He testified that he was not asked for, and did not give any other advice, about what chances there were of a survivor. When advised of Staff Insp. Neadles’s evidence that he had told him that he did not believe that there was much likelihood going forward of any of the victims surviving and no real chance of anyone having survived the collapse, Dr. Feldman testified that he did not recall any such conversation. He did recall conversations in the command tent when Staff Insp. Neadles was present when he spoke with paramedics about how to be prepared for life-threatening complications, but that such complications were to be expected and they were preparing to treat them if encountered.<sup>23</sup>

Dr. Feldman also gave evidence about “crush syndrome,” which describes the condition sometimes caused when parts of the body are crushed after a structural collapse, causing muscle breakdown and the release of potentially toxic muscle cell components and electrolytes into the circulatory system. It can cause local tissue injury, organ dysfunction, and metabolic abnormalities. Experience with earthquakes that caused major structural damage has shown that the incidence of crush syndrome is 2 to 15 percent, with approximately 50 percent of those with the syndrome developing acute renal (kidney) failure. When a part of the body that has been crushed is released, the formerly trapped person may go into shock, potentially causing lethal cardiac arrhythmias and the release of toxins leading to kidney failure.<sup>24</sup>

Dr. Feldman testified that he had studied this syndrome and it was part of his training when working with HUSAR/TF3. It is treatable. It can be detected by cardiac monitoring of those rescued, and treated by injecting sodium bicarbonate and dextrose and administering fluids intravenously that contain saline and sodium bicarbonate. Dr. Feldman instructed the paramedics on the team about how to mix an infusion for this treatment and how to monitor the patients for arrhythmias. This was information he expected to be part of the general understanding of a medical technician trained for a response to structural collapse.<sup>25</sup>

Dr. Feldman was told that Staff Insp. Neadles had testified that he had told him that even if someone had survived under the rubble, once the pressure was released and the rubble was pulled off, there would be a very slim chance of survival. Dr. Feldman testified that he did not believe he would have said that. He said he would have made the paramedics aware, and probably Staff Insp. Neadles as well, that there are life-threatening complications to removing a heavy weight off a patient who has been crushed and that they were anticipating and preparing to treat that. He would not, he said, have estimated the probability of survival after removing a piece of concrete. That requires an individual assessment of the patient, based on their vital signs and clinical state. It was a risk that he was expected – and prepared – to deal with.<sup>26</sup>

I accept Dr. Feldman's evidence. He sent the email Monday morning containing his opinion that it would not be acceptable medically to consider the operation a recovery rather than a rescue until Tuesday afternoon.

That clearly was his opinion at the time. If he had earlier given contradictory information to Staff Insp. Neadles, I expect that he would have said so. His opinion as to the appropriate treatment is consistent with the publication from the United States Centers for Disease Control, a recognized authority on public health issues, identified as such by Dr. Feldman, and well known to all. Staff Insp. Neadles told the CCG meeting at 8:30 a.m., and (as described below) the noon press conference, that the rescuers had positive signs of life from the LifeLocator device, and Dr. Feldman did not suggest that there was any reason to doubt the accuracy of those signs. I conclude that Dr. Feldman did not tell Staff Insp. Neadles, at any time, that any persons trapped in the rubble were probably dead by Monday. Nor did he tell him that, even if a victim had survived, there would be only a slim chance of survival after he or she was released from the rubble. The information available to Staff Insp. Neadles on June 25 was that he could not safely assume that Ms. Aylwin, the woman trapped under the rubble at the site of the signs of life, was dead.

**Dr. Feldman sent the email Monday morning containing his opinion that it would not be acceptable medically to consider the operation a recovery rather than a rescue until Tuesday afternoon.**



## Noon: The device shows movement, and Capt. Comella decides to have rescuers removed from the site without waiting for Mr. Cranford's engineering assessment

Capt. Martin McRae testified that he had not detected any movement while carrying out approximately hourly inspections of both the measuring devices at the top of the escalator and the one on the ground floor. He observed the upper level device from outside the penthouse on the roof, at a distance of 50 or 60 feet, and consequently could not get a close view of it. He was able to get quite close to the ground floor device. His notes, recorded in the HUSAR/TF3 compilation of notes, indicate that he checked the upper device at 11:45 a.m. and there was no movement. The notes also indicate that he measured the upper device at 1:06 p.m. and 2:20 p.m., and the lower device at 12:47 p.m. and 2:09 p.m., and no movement was shown.<sup>27</sup>

At approximately noon, before Mr. Cranford had completed his calculation of the load being supported by the beam, Capt. Comella testified, with his memory assisted by his notes, that he inspected the upper-level device from inside the elevator lobby (much closer than Capt. McRae) and noticed that it had moved approximately 2 millimetres. After checking with Capt. McRae, he was told that the movement had occurred in the last 20 minutes. His note indicated that he had inspected it with an engineer.<sup>28</sup>

Mr. Jeffreys recalled inspecting it just before lunch, and testified that he had done so with Capt. Comella and Mr. Cranford. (Mr. Cranford testified that he did not inspect the measuring device.<sup>29</sup>) Mr. Jeffreys's recollection

was that it had moved more than 2 millimetres – probably about  $\frac{1}{2}$  to  $\frac{3}{4}$  of an inch. He took a photograph of the device at that time from a distance of about 5 or 6 feet, and it showed a differential of somewhere between a quarter and a third of the edge of a two-by-four, which is  $1\frac{1}{2}$  inches thick. He had been told that the blocks were flush when the device was first set up. The photograph can be seen at figure 2.5.1. Mr. Jeffreys also testified that he told Capt. Comella at the time, and Mr. Cranford subsequently, that it was very significant and indicative of a potential collapse of the area.<sup>30</sup>

I have reviewed the evidence of Mr. Jeffreys and the photograph he took, in an attempt to reconcile the difference between his evidence that the block had moved  $\frac{1}{2}$  to  $\frac{3}{4}$  of an inch, Capt. Comella's evidence that it had moved 2 millimetres, and Capt. McRae's evidence that it had not moved at



**Figure 2.5.1** Measuring device at top of stairs

Source Exhibit 6226

all. Capt. McRae observed the blocks from a distance, and a small movement may have been difficult to discern. Mr. Jeffreys's evidence was, to a large extent, affected by the photograph he had taken. That photograph clearly shows a differential in height between the two blocks which, from Capt. McRae's evidence, were flush when the device was first constructed. The size of the blocks, however, and therefore the amount of the height differential, is difficult to determine. Capt. Comella's evidence was based on a note which was not contemporaneous. His conclusion that the movement had occurred in the previous 20 minutes was based on Capt. McRae advising him that, when he had inspected the device, he had detected no movement. Since Capt. McRae never detected

any movement, even over the next two hours, his failure to notice movement 20 minutes before cannot be the basis of a conclusion that the movement had happened in that period of time. All I can safely conclude is that there was a height differential between the two blocks which indicated to both Capt. Comella and Mr. Jeffreys at noon that the escalator structure had moved. That caused Mr. Jeffreys to advise Capt. Comella that the structure was very unsafe.

At 12:05 p.m., as recorded in the HUSAR/TF3 notes, Capt. Comella asked Capt. McRae and Capt. Chuck Guy to have all the rescuers leave the rubble pile while he had the engineers determine, based on the movement, the extent of the stress on the escalator. This decision was made before he had any calculations from Mr. Cranford. He testified that his primary concern was about a possible secondary collapse of the whole building – as he put it, “Certainly we had rescuers in harm’s way but we would have leveled a lot more – we would have created a lot more damage if the building had catastrophically failed with us in it . . .” He confirmed that he had no input from engineers before making this decision.<sup>31</sup>

Capt. Comella testified that, after he ordered the workers to leave the pile, he spoke with Cmdr. McCallion and told him they had to think of the mission as either a rescue or a recovery. His evidence was that, if they were going to continue it as a rescue, they would have to bring in some heavier equipment to remove the “obstacle” of the escalator. But if it was going to be a recovery, the local demolition crews would be able to do the work. He testified that the “heavier equipment” he was thinking of was the Priestly demolition equipment, which would be ordered later that evening after Premier Dalton McGuinty spoke to Staff Insp. Needles and others, but that he did not mention that name to Cmdr. McCallion.<sup>32</sup> Both Cmdr. McCallion and Staff Insp. Needles denied having received any such suggestion.<sup>33</sup> I have difficulty accepting Capt. Comella’s evidence on this point. Had such a suggestion been made, I would have expected some reference to it in the evidence of some other witness.

## **12:05 p.m.: Press conference – public advised that the situation is dangerous, but still signs of life and new approach being taken**

A press conference was held at 12:05 p.m., the precise time at which Capt. Comella ordered all rescuers to leave the rubble pile. The transcript shows that Staff Insp. Needles told the public and press:

The Toronto Heavy Urban Search-and-Rescue team assisted by the OPP and the Elliot Lake fire service has been diligently working through the night. Since our last night, we managed to, with the assistance of the large crane operators, remove the damaged I-beam that had collapsed within the structure . . . This morning around 4 o’clock, the OPP utilized a piece of equipment that they have to again determine that there was signs of life from the one same location that we had indicated yesterday. And again, we’re still diligently working as fast as we can towards that person. Unfortunately, we’ve probably had a setback in that the structure, after some of the weight has been removed from some of the other parts that had fallen and a beam had been removed, is still shifting and is still unstable. It has become more unstable for us. The escalator inside is now shifting and we’ve had to remove our crews to reassess our entry point. That’s not to say we have stopped working. We have now gone back to the other avenue from the north to now come back from that entrance to now start shoring and putting up weight posts and supporting the roof above to keep moving toward that void where that person was located this morning. So we’re still working that way. We will not be able to use the crane as much as we did because that area that they were lifting and removing large slabs from is now a no-go situation for us to be there. We’re still scared of it. It even has the potential of falling down. We put on some technical equipment to try and assess how much movement there is in that a [sic] of the building. But it is still very unstable and

very unsafe and we have to be very careful with every move that we make within that structure. We are still moving forward. That rescue. Now, to give you a time frame, I just can't do that because now we're reassessing the whole operation and moving forward in what was now a different direction. And so we don't have a time frame on when we might be able to make contact with anybody there.

...

Q. You said that there were signs of life this morning. What signs of life?

...[Staff Insp. Needles]: Well, the piece of equipment that the OPP has is called a life detector – and it has the capability to – it is sort of x-ray machine that can look through the concrete slabs and can determine on the machine whether there is someone breathing within that structure or within that void. And they did come up with that positive sign again.

...

Q. ... Are there any confirmations of fatalities at this point (inaudible)? Were there any other?

... [Staff Insp. Needles]: There was one other fatality within the structure that we confirmed.

Q. Is there any identification at this point?

... [Staff Insp. Needles]: No, at this point, there is only the sighting of the arm and the leg. We have no other signs. We have not gone anywhere near that victim at this time as we are focusing on the rescue of the other one first.

...

Q. My question is about the individual who at 4 a.m. was once again – there were signs of life shown. Can you clarify if that is the same person or came from the same area from the tapping? And follow-up, is that the person who is believed to be trapped under the car? Again, is it the tapping person? ...

... [Staff Insp. Needles]: The answer to the question is "yes." That's the same person. That's the only person we've actually had contact with, on the site. So it would be the same person who was tapping. The same person who has been, there has been hits by our search dogs. That is the only person we've had contact with.<sup>34</sup>

Staff Insp. Needles testified that, when he made these statements, the shifting of the building had required the operations around the escalator to stop. The plan had moved from a crane operation to remove the debris to a shoring operation along the perimeter of the collapse zone. At some point in time they would have to determine how to move from the perimeter of the pile to the area where the victim was located. And nobody knew how that would be done.<sup>35</sup>

Staff Insp. Needles could not recall who provided him with the information about the OPP's use of the LifeLocator device, although he testified that it was not someone from the OPP. He candidly testified that "I'm not aware of anything in relation to that LifeLocator."<sup>36</sup> He did not take any steps to question the validity of the results, nor did he instruct anyone on his team to confirm their validity.<sup>37</sup>

Cmdr. McCallion testified that he provided Staff Insp. Needles with the results of the LifeLocator device that he reported at the press conference. Cmdr. McCallion received news of the device's results from Capt. Comella, who advised him that the machine had given an indication of breathing that would have placed the victim below the surface of the floor. This apparent impossibility was explained to Cmdr. McCallion as being a result of the device's margin of error. He did not make any inquiries to verify the accuracy of the result or to question the explanation relating to the margin of error.<sup>38</sup> Like Staff Insp. Needles, he also candidly admitted: "I'm not familiar at all with this LifeLocator device."<sup>39</sup>



In light of Staff Insp. Needles's admitted ignorance of the LifeLocator device as well as the identity of the person who provided him with the results, I have serious reservations about the wisdom of the decision to have reported – unequivocally and without qualification – the readings at the press conference. This had the effect of raising the hopes of the community and the victims' family members, perhaps without any real basis. In his testimony, Chief Officer aptly articulated the detrimental impact of the release of such information:

- Q. Right. What I am asking you is did you have any misgivings about the accuracy of the results of the LifeLocator?
- A. Only the fact that it was new and it was one, one piece. I don't know enough about the equipment to determine how accurate it is, and this is back to exactly what do you release and don't release. In hindsight, I would say no, we probably should not have communicated that.
- Q. And if you say we shouldn't have released it, why is that?
- A. Because the accuracy of it. Somewhere through I will say the TF-3 I got a little bit of impression that the confidence level wasn't really high on it, and I don't know if that was on the equipment or on different conflicting information that they might be receiving. But I don't have enough detail to answer that solid for you.
- Q. But this is information that was given to you prior to –
- A. Yes.
- Q. – the press conference?
- A. So you take it for what it is, and that is why it is there.
- Q. And I gather the misgivings would be based on the fact that you don't want to, without good reason, raise people's hopes?
- A. Absolutely. I mean, and that is the problem. It gets very difficult to – and especially in my case, I'm not an expert on these equipment, so you can only go with what comes to you. Mr. Needles would have a better understanding of it, but I'm sure the operators of that equipment when it comes to you take that information for what it is ...<sup>40</sup>

## Early afternoon: Decision is made to cease all operations

### 1:30 p.m.: Mr. Cranford determines a beam is significantly overloaded and can, with significant problems, be partially supported by wood shores

At approximately 10 a.m., Mr. Cranford began to calculate the load that was being supported by the beam under the escalator. He proceeded on the assumption that the beam was also supporting the hollow core slabs from the parking deck and the second floor of the Mall, together with the topping on the slabs, and any other material, such as furniture and signs, that had been on the slabs before the collapse. He assumed that each of these materials would have a standard weight, using ordinary design assumptions. He then calculated the amount of force on the beam in kilonewtons per metre.\* Since the escalator was on an angle, the weight which was sitting on it produced a force both vertically (downwards) and horizontally (north, toward the rubble pile and collapse zone) which would both have to be resisted by the beam. Mr. Cranford calculated that there was a downward force of 110 kilonewtons per metre and a horizontal force of 94 kilonewtons per metre acting on the beam.<sup>41</sup>

• • • • •

\* A kilonewton is a measure of force.

Mr. Cranford was able to calculate the amount of the load using standard design assumptions, paper and pencil, and a calculator which he purchased from the drugstore across the street from the Mall. He was not asked to bring a computer (or anything else) with him when he was called out. As a result, he was not able to determine the ability of the beam to support the load. Had he had a computer with the appropriate software loaded into it, he could have made this calculation himself, and it would have been easier and quicker. Instead, he had to telephone the information to colleagues at his firm who, despite being very experienced in using the necessary software, had not witnessed the specific situation and had to have it explained.<sup>42</sup>

Mr. Cranford sent his initial calculations of the force being supported by the beam to his office at approximately 11:30 a.m. He received results at approximately 12:30 p.m., made some revisions and sent them back to the office at 1:15 p.m., and received the updated results at 1:30 p.m.<sup>43</sup> He was told that the beam was supporting 4.28 times the load it would theoretically be able to carry. He testified that a simple analogy would be that, if the beam was originally designed to hold 100 pounds, it was now supporting 428 pounds. The analogy is not quite correct because there were different types of forces involved – horizontal, vertical, shears, bending moment – all of which contribute in different ways. But one conclusion was apparent: If it failed as a result of these forces, the result would be catastrophic.<sup>44</sup>

To determine if shoring was a feasible option, Mr. Cranford then calculated what shoring would be required to prevent failure. Two options for shoring material were available on site: 6-inch square wooden posts; and hollow structural section steel posts, both 5 inches square and 4 inches square, each with a ¼-inch-thick steel.<sup>45</sup> His initial calculation was made assuming that 6-inch square wooden posts would be used, since that was the preferred material used by HUSAR/TF3. He determined that, in order to provide enough support to the escalator, he would need to use 11 posts on each side of the escalator. While it was theoretically possible to have placed those posts in that space, they would have occupied almost the entire width of the hall on each side – with room for only 4 or 5 inches between each post.<sup>46</sup>

## **Before 2 p.m.: Staff Insp. Neadles orders that all responders be withdrawn from the building**

It is clear that before 2 p.m. on June 25 a decision was made that all responders should leave the building and operations stop. The evidence of how and when that occurred, and who was consulted or took part in the decision, is contradictory.

### **Staff Insp. Neadles's evidence: his decision, based on meeting with Cmdr. McCallion, Capt. Comella, Mr. Cranford, and Mr. Jeffreys**

Staff Insp. Neadles testified that Cmdr. McCallion called him shortly after the noon press conference and asked him to come back to the site. Cmdr. McCallion told him that Capt. Comella had advised him that the measuring device had shown that the building had moved and that it was now unsafe for the teams to be inside. Staff Insp. Neadles testified that he then returned to the command tent and spoke initially to Cmdr. McCallion, and then to Capt. Comella, Mr. Cranford, and Mr. Jeffreys, who he described as the "engineering brain trust that had been working collectively over the last several hours." This conversation, which he said was "concentrated [and] very focused," took place in the command tent. He testified that he was certain that Mr. Cranford was there, and that the last thing he recalled him saying was that he had to "get back in touch with Toronto to confirm his numbers." He did not believe that Chief Officer was present.<sup>47</sup>

Staff Insp. Needles testified that Capt. Comella started the conversation in the meeting in the command tent by saying that the mechanism he had put in place had shifted significantly and, based on what the engineers had said, the escalator with the concrete on top was overstressed and subject to failure (“the number at that point in time that I recall was just over 100-and-some-per cent stressed”), with the risk of collapse being almost imminent. The recommendation to him was that they remove all the workers from the building. Capt. Comella was the spokesperson:

[He] was making his point very well and succinct to me that it was – it had moved, and drastically, significantly, I’m not sure of the term, but it was now in a position that it was at risk of falling, not only falling down but moving, falling, which was more significant for us was falling forward. He put it in that downward, forward motion.<sup>48</sup>

Staff Insp. Needles asked the engineers if they agreed and they all said yes. This was a short conversation, maybe two to three minutes from start to finish.<sup>49</sup> Staff Insp. Needles testified:

With the recommendation that came from Tony [Comella] and the information I had received from Mike [McCallion], I then made the decision that the building was an unsafe work zone for our members to be conducting our operation and then ordered that all members be withdrawn from the building. They had already been pulled out, but then I went one step further to say that we will not be at this point in time going back in.<sup>50</sup>

As I describe below, Staff Insp. Needles sent an email to Carol-Lynn Chambers, manager, Emergency Planning, Office of the Fire Marshal, asking her to call him as soon as possible for an update. He testified that he sent this email approximately 30 minutes after making the decision to withdraw all members from the building. During this time, he was involved in conversations with Cmdr. McCallion and others, and Capt. Comella and the group “went off and somewhere else.” If his memory is correct, he made the decision at approximately 1:30 p.m. It was certainly made before 2 p.m.<sup>51</sup>

Staff Insp. Needles testified that, when he made the decision, he “had no further indication from Comella or the engineers that there was a viable option at that point.”<sup>52</sup> He described the decision he made as being to suspend the rescue, and not stop it, because “I did not have the understanding of how to go forward from there. But we weren’t giving up hope of how we were going to do that.”<sup>53</sup>

### **Fire Chief Paul Officer’s evidence: decision made by unified command at a meeting with Staff Insp. Needles, Cmdr. McCallion, Capt. Comella, Mr. Jeffreys, and Bob Thorpe; MOL to order site closed**

Chief Officer gave different evidence. His scribe made the following notes on June 25:

1328 hrs – HUSR [sic] Bill informed confirmed scene movement & scene completely unsafe ppl ordered off scene

1329 hrs back to scene

1332 hrs chief joined a consult group w[ith] unified command<sup>54</sup>

His own notes, compiled some days after the event with the assistance of the scribe’s notes and his review of the recordings of audio transmissions by the firefighters, state:

Approx 13:28 HUSAR Bill informs Fire Chief that the building has significant movement. The scene is completely unsafe and all personal [sic] are ordered out of hot zone.

Approx. 13:33 Command meeting to discuss building movement. Fire Chief, HUSAR IC and command staff, MOL, OFM staff.<sup>55</sup>



Chief Officer testified that the notation at 1:28 p.m. (1328 hrs) was when he got the “quick version.”<sup>56</sup> In his evidence, Staff Insp. Neadles testified that the personnel were ordered out of more than just the “hot zone” – they were required to leave the building completely.<sup>57</sup> Chief Officer testified that after he had received this information, he went to the command meeting at 1:33 p.m., together with Staff Insp. Neadles, Cmdr. McCallion, Capt. Comella, someone from the MOL (“I think it was Roger Jeffreys, if I remember correctly”), and an individual, probably Robert Thorpe, from the Office of the Fire Marshal. He testified:

This was follow-up from the movement being monitored. The engineers were involved. The Ministry of Labour engineer was involved. The building was continually shifting, and when I say “the building”, the escalator, the escalator stairs. There is two escalators on the top floor and one below and a staircase on the – as well in there. It was continuing to move. They were monitoring it. The engineers determined that the beam that was supporting that escalator was, I can’t remember exactly, I think they said 300 per cent overcapacity. They had no idea of why it was still standing.

I was advised that the MOL, Ministry of Labour, Mr. Jeffreys was so concerned that they would place an order on to not permit people to enter the building.

...

So the engineers and through Bill they explained the situation. It was overcapacity. When it did come down, it would come down and it would be I think they used the word “catastrophic” and there would be absolutely no warning. ... when the engineers came to Bill Neadles in charge of the rescue sector, he took that advice and determined that he would have to pull the crews.

That information comes to me, and you don’t have a whole lot of choice in this matter and I had to follow in line with that.<sup>58</sup>

Staff Insp. Neadles could not recall such a meeting. When he was shown the notes of Chief Officer and his scribe, he testified that they may have been referring to what they heard when they were in the vicinity of his conversation with Capt. Comella and the two engineers. He then testified that they may have been referring to something that happened after that conversation, when he had “many conversations with many people.” He also said that he may have had such a meeting between 1:33 p.m. and 1:50 p.m., which is the time when Mr. Thorpe indicated in a later email (described below) that the decision was made to terminate the rescue.<sup>59</sup>

### **Mr. Jeffreys’s and MOL witnesses’ evidence: no such meeting, no such order**

The Ministry of Labour witnesses were unanimous in denying they were present at such a meeting or issuing such an order. Mr. Jeffreys testified: “I could categorically tell you that I was never at a command meeting. Any meeting that I attended, I documented.”<sup>60</sup> He recalled meeting with Mr. Cranford at 2 p.m. in the tent together with Brian Sanders, the engineer employed by the ministry. He testified that Mr. Cranford had his Toronto office run some calculations, and that the load being supported was 428 percent of the design load,\* so he was extremely concerned. Mr. Jeffreys did not believe that Capt. Comella was there at the beginning of the discussion, but he joined them at some point and they spoke to him about the issue. Mr. Jeffreys testified that it was his opinion at the time that the building would fail, although he could not say when the failure would occur. He said:

I told Mr. Comella that I don’t understand why, at this point, it hasn’t failed and that the area around the structure at that point in time was – posed an extreme risk. That was my words to him “extreme risk”.<sup>61</sup>

.....

\* Mr. Jeffreys explained the difference between a member’s “design load” and “capacity.” Some witnesses testified that they had been told that the beam was just over 100 percent over capacity, and others that it was at 428 percent of its design load. A structure is typically designed to support a load which is only one half of its actual capacity, to build in a “safety factor.” A beam which could support 200 pounds is therefore designed to support 100 pounds – which is its “design load.” If it is supporting 400 pounds, it can be described as supporting 400 percent of its design load. Since its actual capacity is twice its design load, that beam is described as having a capacity to support 200 pounds. If it is supporting 400 pounds, it is supporting twice its capacity, or 100 percent in excess of its capacity.

Mr. Jeffreys testified that, although he had told Capt. Comella that this was an extremely high-risk area, he had never told him that it or any area was too dangerous to enter. Nor had he or, to his knowledge, anyone from the MOL, ordered or recommended on June 25 that work stop in any area. He did not tell anyone that steel posts would not safely shore up the beam under the escalator. Nor did he know that workers had pulled out of the area at that time.<sup>62</sup>

Mr. Sanders, the MOL engineer who had come to the Mall to assist in the investigation of possible offences under the *Occupational Health and Safety Act*, testified that Mr. Jeffreys asked him to speak with Mr. Cranford. Only the three of them were present during the discussion. Mr. Cranford told them that the beam supporting the escalator was 428 percent stressed, and the ones parallel to it were 137 percent stressed. He understood that to mean that they would ultimately fail. He testified that he was certain that this discussion took place just before 2 p.m. because, immediately after, he was told to go over to the beam that had been cut down the previous night and was being photographed by the OPP identification officer. He had the officer stop photographing the beam so he could look at his camera to see the pictures that had already been taken, and subsequently noticed that there were no photographs (which were time-stamped) of the beam taken between 2 p.m. and 2:08 p.m., which must have been while he was reviewing the first set of pictures.<sup>63</sup> This evidence is inconsistent with Mr. Cranford having been the “MOL engineer” present at a command meeting at 1:33 p.m.

**Mr. Cranford told them that the beam supporting the escalator was 428 percent stressed, and the ones parallel to it were 137 percent stressed. He understood that to mean that they would ultimately fail.**

Donald Jones, the MOL inspector, testified that he never attended a meeting in the command tent. He never issued a verbal order and was not aware of any verbal order being issued by any of the MOL employees on the site. He testified that, if either Michel Lacroix (also an MOL inspector) or Mr. Jeffreys had issued an order, they would have told him because he was the lead inspector. He issued a written order later on June 25, which I describe below.<sup>64</sup> Mr. Lacroix testified that he had no discussions with Mr. Jones, Mr. Sanders, Mr. Jeffreys, or anybody else about an order that the MOL could place on the building. He said that he “barely saw” Chief Officer.<sup>65</sup>

### **Cmdr. McCallion’s evidence: initial decision based on Capt. Comella’s recommendation, confirmed by Staff Insp. Neadles, before hearing from the engineers; subsequent decision made by Staff Insp. Neadles, with no input from the engineers**

Cmdr. McCallion testified, with his memory assisted by his notes, that at approximately 1:20 p.m. he met Capt. Comella at the command tent in the parking lot on the south side of the Mall. Capt. Comella told him that the building was continuing to move and was unsafe and that teams should not be allowed inside. Cmdr. McCallion spoke to Staff Insp. Neadles and told him this and that the building was unsafe. His note at “1320” reads in part:

Comella confirms building is continuing to move – Bldg unsafe. – Teams should not be inside pile. Notify B. Neadles that teams need to be removed from pile Bldg unsafe – Agreed!<sup>66</sup>

Cmdr. McCallion testified that, during this conversation, Staff Insp. Neadles asked that the dogs and the LifeLocator device be used again to get an update on the status of the two victims.<sup>67</sup> After he spoke to Staff Insp. Neadles, Cmdr. McCallion was in the command tent with Capt. Comella, and there were no engineers present. He then telephoned Sgt. Gillespie and asked to meet him on the north side of the building. He and



Capt. Comella walked around the building and were joined by Mr. Cranford either during the walk or after they arrived. They met Sgt. Gillespie on the north side.<sup>68</sup>

Cmdr. McCallion testified that during the walk over, or shortly after they arrived, he discussed the status of the building with Capt. Comella and Mr. Cranford. Capt. Comella said that the building was moving and that the escalator section was unsafe and was 110 percent above its fail-safe capacity. Mr. Cranford reiterated Capt. Comella's statements. Cmdr. McCallion's notebook records the following at approximately 2:00 p.m.:

Advised by Comella/Engineer – I beam supporting escalator is 110% beyond fail safe limit. Not even sure why bldg. still standing – will fail [without] warning<sup>69</sup>

Sgt. Gillespie testified, corroborated by his contemporaneous notes, that at 1:15 p.m. on June 25 he met with Cmdr. McCallion and Capt. Comella at the Hotel entrance on the north side of the Mall building. They told him that the site had been assessed by two MOL engineers and the HUSAR/TF3 engineer and that it was “far too dangerous to enter” and that the MOL had stopped the rescue, based on the information that the beam was overloaded. He had made a note which said: “No further access to collapse area allowed per MOL. All operations to cease shortly. Too dangerous to shore stair beam pillars, etc.” Sgt. Gillespie testified that he had made the last reference because Cmdr. McCallion had told him that, given the forces acting on the beam, there was no guarantee that, even if they had installed steel shores, it would have been sufficient.<sup>70</sup>

Cmdr. McCallion testified that, when they met Sgt. Gillespie, who was with another officer, they were joined by Sgt. Scott Fowlds, the HUSAR/TF3 canine officer. He and Capt. Comella told them that “the engineers” had discussed the building and felt it was unsafe to continue the operation as it currently stood. He told Sgt. Gillespie that nobody was going to be allowed back in the building. This was confirmed by his (Cmdr. McCallion's) note: “Team pulled from pile – Meet with OPP TL [team leader]/HUSAR TL – STOP WORK.” He denied telling Sgt. Gillespie that the work was stopped as a result of the MOL issuing a stop-work order; it was his evidence that he merely said that the MOL was part of the engineering group which had discussed the building.<sup>71</sup>

### **Mr. Cranford's evidence: his calculations discussed with Capt. Comella, Mr. Jeffreys, Mr. Sanders, and Sgt. Gillespie; no discussion with or advice directly to Staff Insp. Neadles or Cmdr. McCallion**

Mr. Cranford testified that he discussed his initial calculation, which he had received back from his Toronto office, with Capt. Comella, Sgt. Gillespie, and Cst. Waddick at approximately 1:35 p.m. The time was recorded in his notes prepared after he returned to Toronto.\* Mr. Cranford testified that he told Capt. Comella that it was possible to put in sufficient shoring to support the vertical load but that, if the load continued to move laterally toward the collapse zone, the shores would not be nearly as effective. Furthermore, the posts would have had to be installed on a sound surface clear of debris, and the number of shores required meant that essentially all the rubble would have had to be cleared out on either side of the escalator. Mr. Cranford testified that Capt. Comella was concerned, after hearing his conclusion, about the amount of effort, time, and work – and the number of people working under the escalator – that would be required to install the system.<sup>72</sup>

Mr. Cranford testified that he spoke to Mr. Jeffreys, Mr. Sanders, Sgt. Gillespie,<sup>†</sup> and Cst. Cox about his initial calculation of the load supported by the beam, but did not recall speaking to them, or Mr. Sanders, about his

.....

\* Mr. Cranford testified that his notes were “reasonably accurate ... maybe within a half an hour”: Cranford testimony, September 9, 2013, pp. 24809–10.

† Sgt. Gillespie testified that he did not speak to Mr. Cranford on June 25, and had no idea what his opinion was on whether it was safe to continue to work: September 4, 2013, pp. 23880–1.



wood-shoring calculation. Mr. Cranford did not recall speaking to Staff Insp. Neadles or Cmdr. McCallion about his calculations.<sup>73</sup> He testified that he “very rarely” dealt directly with Staff Insp. Neadles, and that neither he nor Cmdr. McCallion ever asked him directly for advice during his time in Elliot Lake, although both were present in a few conversations that he had with other members of HUSAR/TF3.<sup>74</sup>

Mr. Cranford testified that:

- It was not his opinion at any point in time that the building was ready to collapse completely and he never said that to any member of HUSAR/TF3 or UCRT.
- He did say that one particular area was at risk of failure due to the stress levels (although he did not know when that would happen).
- He never told anyone that it was unsafe to proceed further without a different approach, although he had said that, if the steel in the beam were to fail, it would likely be a catastrophic failure.<sup>75</sup>

**Capt. Comella’s evidence: no recollection of decision to remove teams from the pile, or of speaking to Staff Insp. Neadles, Sgt. Gillespie, Mr. Cranford, Mr. Jeffreys, or Cmdr. McCallion about it; he was waiting for decision**

Capt. Comella’s evidence about the situation was confusing. He was read Cmdr. McCallion’s notes about the meeting at 1:20 p.m. that indicate that Capt. Comella told him that the building was unsafe and the teams had to be removed from the pile. He then testified that he had no direct recollection of that particular conversation, although he did recall talking about the stress on the beam because it was “just so over-stressed that it could fail at any second” and that “we couldn’t work inside until we had removed that – that issue.”<sup>76</sup>

When asked whether he was present when Mr. Cranford presented the results of his calculations on the beam, he said that he learned of the calculations at a meeting either inside or outside of the command tent.<sup>77</sup> He was specifically asked if each of Mr. Cranford and Mr. Jeffreys was present at that meeting, and his answer was the same for both: “I don’t have a clear recollection of that.”<sup>78</sup> He was asked if Staff Insp. Neadles was at the meeting, and responded: “I’m not a hundred per cent sure he was there.”<sup>79</sup> Nor did he know if Cmdr. McCallion was present.<sup>80</sup> He also testified that he did not recall having a conversation with Staff Insp. Neadles between 12:05 p.m. and 3:05 p.m. when Staff Insp. Neadles announced at the CCG meeting that the rescue was over, although, “if he was present at the command tent when the engineer was talking about how over-stressed the beam was, I may have talked to him briefly.”<sup>81</sup> He testified:

The only thing that sticks in my mind about that meeting is that they had done – the engineers had done some work and some modeling; and the beam was, like, over 400 per cent – some number over 400 per cent – and that shocked me.

I think once I heard that I was – we started talking about – I think I talked to James about, is it possible to – is it – what is the likelihood that we could actually shore this? Is it – is it possible to shore this? We have been working on that question. Let’s revisit it one more time.

But then the common sense of it is: How would we put the people in there to shore it. So, it didn’t take long for us to kind of realize that we couldn’t risk the lives of all the rescuers to be underneath this escalator for such a time as required to shore it.<sup>82</sup>

Capt. Comella was asked if he was present when Cmdr. McCallion told Sgt. Gillespie that the operation had been shut down, and he testified: "No, I was not present for that." He was then told that Sgt. Gillespie had testified that he (Capt. Comella) had been present when Cmdr. McCallion told him that the operation had been shut down by the MOL, and he answered: "I don't have a recollection of that. Not at all. Not at all."<sup>83</sup>

Capt. Comella was then asked what he learned about the decision made as a result of the information about the building and the stress on the beam. He answered:

I don't believe that I was told necessarily anything about it. I was waiting for a decision to come back, whether this was going to be continuing as a rescue or a recovery, and I remember taking steps in the meantime. We couldn't work inside the hot zone, but there was still work to do.<sup>84</sup>

### **Sgt. Gillespie is told that no workers will be allowed in the building, even if signs of life continue**

Sgt. Gillespie testified that, at the same meeting when he was told that the engineers had determined the site was too dangerous to enter, Cmdr. McCallion asked him to send in the UCRT canine units and use the LifeLocator. However, when specifically asked by Sgt. Gillespie, Cmdr. McCallion said that even if signs of life were detected, he would not allow the rescue to be continued. Sgt. Gillespie responded that he would not send his people into harm's way to find out if somebody was alive and then not be able to do anything about it. His notebook corroborated this evidence.<sup>85</sup>

Cmdr. McCallion also recalled the discussion about using the LifeLocator or canine units to determine if there were any live victims in the pile. He had expected that the dogs would be able to be used without the handler being in the building and that the LifeLocator could be used by lowering the operator with a crane. Sgt. Gillespie asked if they would be going back in if they found signs of life. Cmdr. McCallion testified:

And I said, "Not at this time. We're not going back in there. No-one's going back in for now, but we want – Bill wants an accounting of what this current status of the victims were."

Essentially, it's an assessment of – of – it's a – as part of a Site Commander you're doing a complete assessment of the site. The site has now changed because of the ... dynamic change in the load on the escalator column. So, in making your next decisions, to me, knowing the status of the victims is part of that decision-making tree.<sup>86</sup>

### **Mr. Sorel is told to return to Toronto**

Mr. Sorel testified that between 11:30 a.m. and 1:30 p.m., he was on his way to the washroom and ran into Staff Insp. Neadles, Cmdr. McCallion, and Capt. Comella. Staff Insp. Neadles informed him that rescue operations had come to a halt, and said "You won't be going back in that building to do any more rigging." On his way back from the washroom, Mr. Sorel asked if he could be released to go back to Toronto, and Staff Insp. Neadles agreed to release him if he kept his cell phone on and close by. He then returned to Toronto.<sup>87</sup> I note that Staff Insp. Neadles had been in the CCG meeting which started at 11:06 a.m., preparing for the noon press conference. I conclude that this exchange occurred after the press conference and, assuming Mr. Sorel's time estimate is correct, before 1:30 p.m.

## Conclusions about decisions between 1:20 p.m. and 2 p.m.

The evidence does not permit me to be certain about all the important facts concerning the decisions made between approximately 1:20 p.m. and 2 p.m. Few documents were created contemporaneously with the events recorded. Those that do exist – such as Cmdr. McCallion's notes and Chief Officer's scribe's notes – are contradictory. Witnesses do not agree on important points, such as when decisions were made, who was present or contributed to the decisions being made, and even what decision was made. When decisions were made, they were not recorded or communicated in a consistent manner, or sometimes not at all.

I am able to safely conclude, on the balance of probabilities, the following:

- Shortly before 1:30 p.m., Cmdr. McCallion telephoned Staff Insp. Neadles and told him that the building was continuing to move, was unsafe, and the teams should be removed; Staff Insp. Neadles agreed (this is recorded in Cmdr. McCallion's notebook and was confirmed by Staff Insp. Neadles).
- At approximately 1:30 p.m. or shortly thereafter, Mr. Cranford determined, with the assistance of his Toronto office, that the beam supporting the escalator was significantly overstressed and was supporting approximately 428 percent of its design weight, a figure that could be expressed as just over 100 percent over capacity (this is set out in Mr. Cranford's contemporaneous calculations, his after-the-fact chronology, and confirmed in his testimony).
- Between 1:30 and 2 p.m., that calculation was made known to Cmdr. McCallion (as recorded in his notebook beside the notation “~ [approximately] 1400”), Mr. Jeffreys, and Mr. Sanders (as testified to by both of them and Mr. Cranford), and Capt. Comella (as testified to by Mr. Cranford; Capt. Comella's evidence confirmed he learned of the calculation, although he could not recall who told him).
- Mr. Jeffreys told Capt. Comella that the site posed an extreme risk and that he did not know why it had not yet failed; Mr. Cranford told Capt. Comella that the area around the escalators was at risk of failure and, if it failed, it would likely be a catastrophic failure, and this was relayed to Cmdr. McCallion and Staff Insp. Neadles (because it was important information that Capt. Comella thought should be communicated, and because Cmdr. McCallion's notes confirm that he was told by Capt. Comella that the building was unsafe and he passed this information on to Staff Insp. Neadles).
- That calculation was relayed to Staff Insp. Neadles at or about the same time (because either Cmdr. McCallion or Capt. Comella would have considered it important information that he ought to know, and he testified that he did know it).
- Chief Officer learned that the beam was significantly overstressed so that the building was unsafe and all personnel had to leave (because his notes and his scribe's notes record that information).
- Although a number of people believed that the MOL had issued an order requiring that the rescue be stopped, no such order was made (all the MOL witnesses denied making any such order, and no witness testified that they had done so).
- Sgt. Gillespie was asked, at Staff Insp. Neadles's request, to send in a UCRT dog or the LifeLocator device to attempt to detect a sign of life; he was told that, even if signs of life were detected on the rubble pile, no members would be allowed to attempt a rescue (he and Cmdr. McCallion both testified to this, and it was recorded in his notes).
- Mr. Sorel was told he could return to Toronto.
- Staff Insp. Neadles did decide that the building was unsafe and ordered all workers withdrawn (he testified to this, and it is corroborated by the request and instructions given to Sgt. Gillespie and Mr. Sorel).



There are a number of factual issues that I cannot determine. In particular:

- I cannot conclude that Staff Insp. Neadles spoke to any engineers between 1:20 p.m. and 2 p.m. Both Mr. Jeffreys and Mr. Cranford denied speaking to him, and Mr. Jeffreys denied being present at any command meeting. Although Chief Officer testified that he was present at a command meeting where Mr. Jeffreys gave advice, Staff Insp. Neadles could not recall such a meeting. Nor does a contemporaneous document record that he spoke with either of them.
- I cannot conclude that there was a “command meeting” attended by Chief Officer, Staff Insp. Neadles, Cmdr. McCallion, Capt. Comella, Mr. Jeffreys, and Mr. Thorpe. Although Chief Officer’s scribe’s notes record him joining a “consult group w unified command” and he testified to such a meeting, no other witnesses confirmed that evidence and some denied that such a meeting took place.

**I should add that the decision to order all members out of the building, given the information available, was reasonable. The engineering opinions, I have concluded, were probably provided to Capt. Comella, Cmdr. McCallion, and Staff Insp. Neadles and were more than sufficient to determine that, until the building was made more secure, workers would be exposed to significant risk of injury and death.**

I should add that the decision to order all members out of the building, given the information available, was reasonable. The engineering opinions, I have concluded, were probably provided to Capt. Comella, Cmdr. McCallion, and Staff Insp. Neadles and were more than sufficient to determine that, until the building was made more secure, workers would be exposed to significant risk of injury and death. The pictures at figure 2.5.2 show very clearly the amount of concrete that was sitting on the escalator, at an angle inclined toward the rubble pile where the rigging work was being carried out. If the beam supporting the escalator had collapsed, that concrete, weighing several tons, would have been propelled toward the rubble pile.

After the decision was made to pull the workers out, and after their removal, further consultation should have taken place to determine that all possible solutions were considered and evaluated before a final decision to end the rescue was made. As will be seen, that did not happen.



**Figure 2.5.2 Concrete on the escalator**

Source Exhibit 9279; Exhibit 7024

## Families are spoken to inappropriately by Insp. Percy Jollymore

On the previous day, Insp. Percy Jollymore had apologized to Robin Kerr of Victim Services of Algoma because the OPP had not provided regular updates to the families. He said he would ensure that someone went to the Collins Hall to provide information to the families as the rescue operations unfolded.<sup>88</sup> Insp. Jollymore testified that he had made a commitment that he would try to be at the Collins Hall before every press release so that the families would have advance information about what the media was going to hear.<sup>89</sup> The commitment was not honoured.

Ms. Kerr telephoned the OPP Communications Centre sometime after 6:30 that morning and spoke with an officer who told her that they had no information to share. She requested that someone come to the Hall and speak with the families because they needed to know what was happening. The next information the families received was by way of the media reporting about the noon press conference. That was how they learned that there had been signs of life that morning and that someone might still be alive. Ms. Kerr again went to the OPP detachment and asked that someone come and speak with the families. She was told that the inspector was busy at the press conference, which was his first priority, and that he would attend when he was able to do so.<sup>90</sup>

Insp. Jollymore explained his absence by saying that the CCG meeting had been immediately followed by a press release, and he had no time to go to the Collins Hall.<sup>91</sup> Insp. Jollymore did go to the Hall, with Mayor Hamilton, after the press conference. Darrin Latulippe, Doloris Perizzolo's son-in-law, described this visit, which he said was at 1:00 or 1:30, this way:

[We] asked Inspector Jollymore if there was any more information and, you know what I mean, it was not as per se, a heated, but it was vocal – we wanted to know what's happening and his basic response was, and I still remember to this day, there were several people that heard it: "I don't really have to be here. I'm doing you a favour by being here." And I thought, "you're doing me a favour? Don't do me any favours, pal. Go away then. If you didn't want to give me any more information."

He said those were his exact words and that there were probably 35 people that heard it.<sup>92</sup>

Ms. Kerr's notes record this:

2:00 p.m. – Insp. Jollymore [sic] came to speak to families – first time anyone attended in 7½ hours. Insp. Jollymore was very aggressive when he came in. Stated he didn't have to come and speak to families that this was a polite gesture on his part. Informed families they had heard breathing at 4:00 a.m. but no other changes at this time. Still working on removing the rubble – there is 6 feet of rubble that needs to be moved.

Families very upset that police do not feel they should have information before media. Insp. Jollymore stated that he has always attended the hall AFTER speaking to media and that if they had any news where family needed to be informed first that he would be sure to do that.<sup>93</sup>

Ms. Kerr confirmed the accuracy of her note and testified that Insp. Jollymore told them that "his attendance was out of the kindness of his heart. He did not have to come and speak to them. It was not his role, and he was doing that to be polite."<sup>94</sup>

Insp. Jollymore testified that he did not recall making the statement Mr. Latulippe testified to, but he did recall having some exchanges with him. When Ms. Kerr's notes were read to him, he testified that he did "use some words to those effect" but that he did not agree with her that they were not supporting the family. He admitted that the "substance of the conversation" was that he was making a polite gesture to the families by going to the Hall. He did not recall telling Mr. Latulippe that he was doing him a favour.<sup>95</sup>

I accept the evidence of Mr. Latulippe and Ms. Kerr, as corroborated by Ms. Kerr's notes. It was quite inappropriate for Insp. Jollymore to have told the families, who were understandably fearful, stressed, and anxious for news of

their loved ones, that he was doing them a “favour” or “being polite” by speaking with them. It was not a favour and it was not a matter of being polite. It was his duty. He ought to have discharged that duty. He did not do so.

Ms. Kerr spoke of what happens when the police do not keep victims’ families continually updated about their progress in such a situation:

The victims of these – of any crime, starts to feel disassociated from the police and unrespected, and their views are not taken into consideration, and they really need to have that rapport, a uniformed officer or officer with his or her badge at least showing so that they show know *[sic]* that their thoughts, feelings are taking into consideration and that they are involved in whatever the investigation or process may be.

...

Q. And in the absence of that sort of update or information, what happens?

A. The turmoil grows, and speculation rises, and we had individuals from the community coming in and starting to spread what could have been rumours. We didn’t know. So we worked at our utmost to try and stop that because we didn’t want rumours and speculation spreading throughout the hall.

And without information, you begin to think the worst instead of what may be the outcome.

So it is very, very important that the victims are involved and always brought up to date in what is occurring.<sup>96</sup>

I agree entirely with Ms. Kerr. Regular and timely communications with the victims’ families is not only the right thing to do from a humanitarian perspective; it is the right thing to do to ensure that misinformation and its inevitable consequences do not spread.

## 2 p.m.: Fire Department and HUSAR/TF3 are told building completely unsafe and no options available

Chief Officer’s scribe’s notes record the period after the “unified command” meeting at 1:32 p.m. on June 25:

1349 hrs ELFD crew & HUSR *[sic]* called to info group

1400 hrs Above informed all HUSR equipment hydraulic will be removed from area, Crews to go in or remove hydraulics & tools, then area will be reassessed. Significant movement demands reassessment *[sic]*. The beam are 100% over stressed building now completely unsafe for rescue operations. No options are available to secure the area. Reassessment measures will commence. HUSR or ELFD crew as support to reassess area & ops.<sup>97</sup>

Chief Officer arrived toward the end of the meeting. He testified that he understood that Staff Insp. Needles relayed the same information on the reasoning behind the decision that nobody would be allowed to remain in the building – that the conditions were too extreme and that they could not enter. He was asked about the reference to “reassessment” and testified:

That was to try and drive forward – as you can see by the timelines, they are very tight here. There was discussion on how this was going to move forward communication-wise because it would not be very long that the public would become aware of the change taking place on the site, and not just the public but consideration to the families on the change.

And then also discussion started taking place on next steps and the legalities of moving it forward. All efforts at this point were driven strictly on rescue. The conditions of the building were now to the point where they are hampering a rescue to be able to take place, and as it says, the TF-3 felt they exhausted all their options.

Q. And were they offering up any hope of continuing in some other fashion?

A. No. There wasn’t really – I don’t think there was any other options.<sup>98</sup>



## Shortly after 2 p.m.: Rescue changes to a recovery – the team sees no options (and none are sought)

At 2 p.m., Staff Insp. Neadles emailed Ms. Chambers and others at the Office of the Fire Marshal, asking that he be called “asap” for the next update.

At 2:15 p.m., Mr. Thorpe sent an email to a number of employees at the Office of the Fire Marshal, including Ms. Chambers:

As of 13:50 hours [1:50 p.m.] the HUSAR lead, in consultation with both engineers have determined that the building will be deemed closed by the MOL, when the rescue operation is terminated and changed to recovery. [sic] due to the shifting of the escalator and the load that is situated on it. The current load is above 100 percent above its rated capacity. Continuation of rescue and stabilization in the south portion has now been suspended. Measuring equipment in place shows movement of the escalator is continuing and team lead has pulled out all members at the present time.

The MOL engineer has notified his office that this building may soon be ordered closed. This is confirmed by the team engineer.

Simply put by all intense [sic] and purposes, the rescue operation will cease, then the building will be methodically demolished.

This will then move this to a recovery operation.

It has been requested that this operation remain confidential until such time ... that the families are made aware.

NOTE: THIS IS NOT YET CONFIRMED, but will advise as soon as the change to recovery is announced by the Fire Chief.<sup>99</sup>

Mr. Thorpe did not testify. Staff Insp. Neadles testified that he did not speak to Mr. Thorpe and that he recalled no conversations about the MOL around that time. He did not believe that the MOL shut the rescue down and he did not tell Mr. Thorpe that the building would be “deemed closed by the MOL.”<sup>100</sup>

At 2:16 p.m., Ms. Chambers sent an email to Mr. Thorpe and another employee of the Office of the Fire Marshal, saying that Staff Insp. Neadles had just called her.<sup>101</sup> Staff Insp. Neadles testified that he told Ms. Chambers that he had authorized the stopping of the operations.

At 2:22 p.m., Ms. Chambers sent an email to a number of officials in the Office of the Fire Marshal. She wrote:

HUSAR lead Neadles reports they are having to stand down due to structural failure. Other options explored but not viable. Will be changing from RESCUE to RECOVERY mode. See details below as Bob Thorpe confirms from scene. There will be a press conference scheduled TBA.<sup>102</sup>

Ms. Chambers testified that she spoke to Staff Insp. Neadles at 2:05 p.m. She described the conversation in this way:

He said, “The engineers are telling me I have to get my people out. The escalator is moving. I can’t risk leaving them in there.

I said, “Have you looked at other options?”

He said, “I have nothing right now. We’re going to continue to work on the exterior, but we don’t currently have a plan.”<sup>103</sup>

Staff Insp. Neadles testified, when asked about Ms. Chambers’s email, that it was not unreasonable to say that they “may have had that conversation” in which he told her that it would be changing from a rescue to a recovery.<sup>104</sup> He acknowledged that, when a rescue transitions to a recovery, the rescue is over.<sup>105</sup>

It is clear to me that, by this point in time, Staff Insp. Neadles had made the decision that the rescue was over. Staff Insp. Neadles could not, however, explain why Ms. Chambers reported that he had told her that “other options explored but not viable.”<sup>106</sup> It seems clear that no other options were explored.

Staff Insp. Neadles testified that his original decision to stop the rescue had been made as a result of the conversation he described with Mr. Jeffreys, Mr. Cranford, Capt. Comella, and Cmdr. McCallion. Between that meeting and the time he spoke with Ms. Chambers, he said that he was probably having other conversations, but he could not recall any specifics. He did not believe that he informed Chief Officer during that time period, although he must have, if the scribe’s notes are correct about the timing and content of the meetings at 1:32 p.m. and 2 p.m. and if Chief Officer’s evidence is accurate.<sup>107</sup>

Staff Insp. Neadles testified that he did not enter the Mall building on June 25 before calling off the rescue or at any time after making the decision and going to the CCG meeting at 3 p.m.<sup>108</sup> Nor could he recall asking anybody if they had any other options about how to deal with the situation between making the decision and speaking to Ms. Chambers. He solicited no opinions from people in Elliot Lake or elsewhere.<sup>109</sup> He acknowledged that he had the opportunity to talk to his team members before going to the CCG meeting, but said the topic of what the next steps might be did not “present itself as a conversation.”<sup>110</sup> He agreed that at this time he had no options, he was not considering any, and to his knowledge, neither was anybody on his team.<sup>111</sup>

**Dave Selvers of Millenium Crane testified that he was not asked whether he could assist in dealing with the structural instability of the escalator. It was his evidence that, if he had been asked, he had some ideas using his crane and assorted equipment that might have helped.**

Dave Selvers of Millenium Crane testified that he was not asked whether he could assist in dealing with the structural instability of the escalator. It was his evidence that, if he had been asked, he had some ideas using his crane and assorted equipment that might have helped.<sup>112</sup>

Cmdr. McCallion testified that he was present at a later meeting – shortly after 2 p.m. – with Staff Insp. Neadles and perhaps Capt. Comella, in the command tent, when they discussed what steps to take next. It was his evidence that Mr. Jeffreys and Mr. Cranford were not present. He testified that he was not part of a meeting that included Staff Insp. Neadles and both engineers. He could not recall if Chief Officer was at the meeting. He testified that he knew Chief Officer “would have been part of the conversation,” although he did not know if that was at the command tent or

later. They discussed the necessity of the engineers doing a re-evaluation of the scene to let them know what the next steps were. When asked what the decision was at that meeting, he testified, “There was nothing to decide on at that point. We weren’t sure where we were going to go from there.” He testified:

Q. Who spoke to the engineers?

A. Tony would have – to have that discussion with the engineers.

Q. And what would – and what was – you don’t even know if Tony was in a meeting. So how do you –

A. Tony – probably would have been expressed to Tony at some point or – I mean, this whole – the whole piece of the engineer of the work stoppage and the reasons for it was based on what the engineers had told us. It – it makes sense that they – that they – that they’re working on the solutions as to what that’s – the next steps would be.

Q. You’re talking about it makes sense. They probably this. What we’re trying to find out is the what.

A. When –

Q. What happened here?

A. I don’t know. I –

- Q. Was James – was James Cranford summoned, “Come and explain this to us.”?
- A. At that time, no.
- Q. Okay.
- A. Not that I remember.
- Q. Was Roger Jeffreys summoned?
- A. No.
- Q. “Come and explain this to us.”
- A. No, not that I recall.
- Q. Okay. You say “probably asked Tony” to do what?
- A. Come up with that, the next solution. What – what are our options?
- Q. And what did he come up with?
- A. That was what they had they weren’t – they hadn’t come back to us with options yet. There were no options.
- Q. Between – there were no options?
- A. No, there was no options presented to us at that point.
- Q. Between two o’clock and three o’clock, when the CCG meeting took place ... you had solicited options, correct?
- A. Yes.
- Q. Had you been presented any options?
- A. No.
- Q. Had anybody said to you, “We do not have any options.”?
- A. No.
- Q. Who would – who was asked to provide options? Who specifically was asked to provide options?
- A. That would have been the engineering group, through Tony.
- Q. But you weren’t there?
- A. But I wasn’t there for that, no.
- Q. And the engineering group would be what? I mean, you’re all in the same proximity. What was preventing you guys from getting them in the command tent and saying, “Explain this to us.”?
- A. Well, I think Bill – you’d have to talk to Bill. But I believe Bill’s priority was to get to the council meeting at three o’clock and explain to them what was currently happening, that we had stopped our – we suspended our operation at that point and that our – our ability to go forward with what we had wasn’t going to allow it if the building – as the building had indicated it was moving toward us.
- ...
- Q. And so in plain English, the decision that Mr. Neadles came to was the rescue was over, fair?
- A. Yes, fair.<sup>113</sup>

Cmdr. McCallion also testified that he did not learn that Staff Insp. Neadles had decided that the rescue was over until he told him on the walk to city hall from the command tent just before the 3 p.m. CCG meeting.<sup>114</sup> In fact, the decision was made approximately an hour earlier. I see no reason for such an important decision to have been made so hastily.



## 2:20 p.m.: HUSAR/TF3 members engage in “make-work”

Capt. Comella testified that, after the workers had been ordered out of the building, “everybody was on standby” and he was waiting to be advised whether it was a rescue or a recovery.<sup>115</sup> He explained that he and the members of HUSAR/TF3 were doing as much as they could on the outside, waiting for a decision. At 2:20 p.m., he asked Capt. Guy to “secure the loading dock with a raker to enhance our safe access point” on the north side of the building.<sup>116</sup> He acknowledged that this work was completely unnecessary because this part of the building had never been identified as subject to collapse. Capt. Comella admitted that the original intention of this work was to keep the men busy while decisions were contemplated. It had no functional purpose other than public relations because, if people got the sense that the rescue was over, it could be a real problem.<sup>117</sup>

## 2:30 p.m.: Mr. Cranford determines that stabilization may be possible but does not tell HUSAR/TF3

After providing Capt. Comella with his calculations about the load supported by the beam, Mr. Cranford considered whether the steel posts which were on the site could be used to shore up the load on the escalator. He calculated that one steel post on either side of the escalator would be sufficient to support the vertical load. This calculation was done approximately 20 to 30 minutes after he spoke to Capt. Comella about the use of wooden posts. Although steel posts, like wooden posts, must be installed on a stable floor, the floor area required was not much bigger than the post itself, which is 5 inches square. Mr. Cranford did not look at the area around the escalator to determine whether sufficient space could be cleared. Although he believed he told someone that he had concluded that one steel post on either side would support the vertical load, he could not recall whom he spoke to. He explained that, by the time he had done these calculations, which was at approximately 2:30 p.m., he was asked to join a number of workers on the north side of the Mall and he did not believe anyone was still in the building. He testified that, at that time,

there was a lot more going on around the site. That is when we started hearing that people weren't going to be allowed back in and that there was a news conference coming up, and they were going to announce something. But at the time I did not – I didn't know what was happening, but there were not – I couldn't really find anyone to speak to. Things were moving quickly.<sup>118</sup>

Mr. Cranford testified that he considered a number of other ways of supporting the beam under the escalator and preventing horizontal movement. In addition to the wood and steel posts, he considered the installation of a strut from the beam across the collapse zone to the columns opposite the escalator to the north; installing angled tension braces welded to the web of the beam and connected to the next row of columns to the southeast and southwest; and inserting additional beams parallel to the escalator trusses with brackets to fit on the overstressed beam. Each of these was discussed at some point with Capt. Comella and discarded because of concerns about its effectiveness or the safety of the workers doing the installation.<sup>119</sup>

Mr. Cranford also considered another option which he concluded would be safest and easiest. Compression struts – lengths of steel – could have been attached to the beam which ran in an east–west direction south of the escalator (beam F207, see fig. 2.5.3) and run north, on either side of the escalator, to the columns which were beside the escalator partway down its length (the intersections of beams A207 and B206 on the west side of the escalator, and beams C226 and F208 on the east side). They would have been attached to the columns by welding or some other means. That would have prevented the escalator from moving horizontally forward (north) because it would have been anchored or tied back to the beam behind it. If, in addition, one steel post

had been installed on either side of the escalator, thereby preventing downward movement, the beam would have been fully supported. Mr. Cranford testified that this option would have required workers to work under the escalator, but not “right at the edge.” The concrete hanging down in front of the beam would not have interfered with this option. The two approaches, working together, would have, from an engineering perspective, removed the safety issues that were causing concern.<sup>120</sup>

## **Conclusion: Decision to stop the rescue is made without further consultation with Mr. Cranford or Mr. Jeffreys**

Mr. Cranford's evidence was that he did not complete his calculations leading to his conclusion that the combination of two steel posts and compression struts was a feasible option until approximately 2:30 p.m. That time is consistent with his evidence that, when he had finished, the news had already circulated that rescuers were not allowed back into the building and a press conference was coming up. The decision that the building was going to remain closed to workers was circulated widely by 2 p.m., as indicated by

- The email from Mr. Thorpe at 2:15 p.m. stating that the HUSAR/TF3 lead had determined at 1:50 p.m. that the building would be deemed closed and the rescue changed to a recovery.
- The email from Staff Insp. Neadles to Ms. Chambers at 2 p.m. asking her to call him "asap".
- Ms. Chambers's subsequent telephone call to Staff Insp. Neadles at a time estimated by her to be 2:05 p.m., confirmed by her email at 2:22 p.m. in which she advised that the operation had changed from a rescue to a recovery.
- The notes by Chief Officer's scribe indicating that at 2 p.m. the Elliot Lake Fire Department and the HUSAR/TF3 personnel were advised that all HUSAR/TF3 hydraulic equipment would be removed from the area, that the building was completely unsafe, and that there were no options to secure the area.

The evidence of Staff Insp. Neadles and Cmdr. McCallion makes clear that they received no input from engineers (or anyone else) about options between the time that Staff Insp. Neadles announced that the workers would not be going back into the building and the CCG meeting at 3 p.m. The decision to move to a recovery, and its tacit admission that if anyone was alive under the rubble they could not be saved, was made without anyone asking Mr. Cranford whether he had been able to come up with a viable plan to make the building safe.

That decision was also made without further consultation with Dr. Feldman, who had told Cmdr. McCallion and Capt. Comella (and, indirectly, Staff Insp. Neadles) by email a few hours before at 10:54 a.m. that they could not safely assume that a person caught under the rubble was not still alive until 2 p.m. the following day. Had Dr. Feldman been consulted, he would also have had an opportunity to dispel the incorrect information apparently circulating that a person trapped under the rubble was likely to die quickly after a weight pinning the person down was removed.

This lack of consultation was the result, in my view, of a failure to have a clear chain of command and decision-making structure, a clear plan, and clear (and required) communications both up and down that chain of command. Without those elements, it is very difficult, if not impossible, to ensure that decisions are made in a timely manner, with all essential information available to the decision-maker.

## **3 p.m. CCG meeting**

### **Staff Insp. Neadles announces the rescue is over**

As I noted earlier, at the 8:30 a.m. CCG meeting, Staff Insp. Neadles delivered optimistic news: the rescuers thought they had detected signs of life in the pile. At the next CCG meeting at 3:00 p.m., slightly more than six hours later, he delivered the devastating news that he had decided that the rescue was over because of the safety concerns associated with sending men to work on the pile. The clear implication of this news was that the decision had been made with the knowledge that there might be a survivor in the rubble pile.



The message he brought to the CCG meeting was stark: the rescue was over! There was no equivocation or qualification to it that could offer hope of any sort for a positive ending to this tragedy.<sup>124</sup> He explained to the CCG members the reason for the decision, including the fact that the beam supporting the escalator could give way at any time which created an unacceptable risk to the safety of the workers.<sup>125</sup> Staff Insp. Neadles concluded his remarks by declaring that the rescue would now be classified as a recovery and that he was turning the operation back to the jurisdiction of the Elliot Lake Fire Department.<sup>126</sup>

The news was totally unexpected. Mr. Jeffreys, who had been observing the suspected movement of the building, was “stunned.”<sup>127</sup> Mayor Hamilton was “shocked”; he had been expecting good news.<sup>128</sup> Natalie Bray described the mood as very sombre after Staff Insp. Neadles delivered the news.<sup>129</sup> Chief Officer, who had earlier been privy to the decisions, said the news knocked the air out of everybody.<sup>130</sup>

Staff Insp. Neadles’s statement to the CCG was, I find, problematic in several respects. Firstly, as he acknowledged during his testimony, the decision to convert a rescue into a recovery was not his to make. It was the incident commander, Chief Officer, who had the authority to decide when the rescue became a recovery.<sup>131</sup>

Secondly, Staff Insp. Neadles was also incorrect in stating that he was turning the jurisdiction back to the Elliot Lake Fire Department; the jurisdiction over this operation had never left it, because Chief Officer was the incident commander. For his part, Chief Officer candidly admitted that he misunderstood the chain of command.<sup>132</sup> He was not aware that, under proper implementation of the Incident Management System (IMS), Staff Insp. Neadles reported to him.<sup>133</sup>

Staff Insp. Neadles, at one point, testified that his decision was to suspend the rescue – not to stop it altogether.<sup>134</sup> I reject this characterization. His message was clear: the rescue operation was at an end. It was repeated on a number of occasions, most noticeably to the families of the victims less than one hour later and to the public and media at a press conference less than two hours later. If the rescue truly had been merely suspended at that time, he would have said so. I find it incredible that he would make such a devastating and demoralizing announcement if he did not believe it to be true.

As Staff Insp. Neadles acknowledged himself, there was nothing preventing him from telling the CCG meeting attendees that they had hit a snag, or that they were going to step back to consider other options and get back to them later, if that had been the case.<sup>135</sup>

### **Staff Insp. Neadles makes a poor choice to attend the CCG meeting**

Staff Insp. Neadles acknowledged that he did not have any time limit by which he had to make a decision about the course of action to take.<sup>136</sup> It is not as though the CCG meeting served as a deadline for any decision. Staff Insp. Neadles could have used that period of time to consider alternative plans of attack. However, he chose to go to the 3:00 p.m. CCG meeting even though it would have been acceptable to decline to attend.<sup>137</sup>

It certainly seems to me that he made a poor choice in electing to attend the CCG meeting rather than to devote time to exploring options. To his credit, Staff Insp. Neadles acknowledged this point in his evidence before me.<sup>138</sup>

**The message Staff Insp. Neadles brought to the CCG meeting was stark: the rescue was over! There was no equivocation or qualification to it that could offer hope of any sort for a positive ending to this tragedy. He explained to the CCG members the reason for the decision, including the fact that the beam supporting the escalator could give way at any time which created an unacceptable risk to the safety of the workers.**

## Serious confusion about the MOL's role and actions

Mr. Jeffreys was the next to speak at the CCG meeting. He explained that there had been movement detected with respect to the stairway and escalator; that neither he nor Mr. Cranford could understand why the structure that was supporting the escalator was bowed because of the weight. He said as well that, when the beam collapsed, it would do so “catastrophically.”<sup>139</sup> Ms. Bray noted that he concluded by stating that there was an “MOL stop order so no one can enter.” There was considerable confusion about the timing and what effect this order would have on the rescue/recovery operation.

Mr. Jeffreys said that his statement was made in the course of answering questions about whether people who had property in the Mall would be permitted to retrieve it. The order he was referring to would prevent that from happening. He said he made it clear that any order would be issued later and would be directed to the owner of the building. He testified that the order he mentioned would not have interfered with the recovery or rescue workers.<sup>140</sup>

**Although the restrictive nature of the order he referred to may have been clear to Mr. Jeffreys, it was far from clear to others in the room. Chief Officer believed the order prevented anyone from entering the building, which would include rescuers.**

Although the restrictive nature of the order he referred to may have been clear to Mr. Jeffreys, it was far from clear to others in the room. Chief Officer believed the order prevented anyone from entering the building, which would include rescuers. He said that he was given this information at the command meeting he attended at approximately 1:30 p.m. that day.<sup>141</sup> He understood that the order Mr. Jeffreys referred to was already in effect. Chief Officer thought that the order had been made verbally and that the ministry personnel were just waiting for the paperwork.

Chief Officer was mistaken about the order, both in its timing and scope. There was no order in existence, verbal or otherwise, at that time. The order that was eventually drafted was only served on the Mall manager the next day. That order specifically exempted the activities associated with the rescue/recovery operations.<sup>142</sup>

However, Chief Officer was not the only person whose understanding of the MOL order differed from that of Mr. Jeffreys. Robert deBortoli, the chief administrative officer of the City of Elliot Lake, thought it was clear that the order, when issued, would prevent everyone, including responders, from entering the Mall.<sup>143</sup> Mayor Hamilton as well said it was quite clear that the order the MOL would issue would prevent anyone from entering. However, it was his recollection that those words were spoken by Mr. Jones, not Mr. Jeffreys. Mayor Hamilton thought the order was already in place.<sup>144</sup> Ms. Bray thought that the order would apply to everyone including rescuers. Furthermore, she believed that everyone in the room held a similar view.<sup>145</sup>

Mr. Jones was the other MOL representative at the CCG meeting. Like Mr. Jeffreys, he was not aware that the rescue had been called off until he heard it at the meeting.<sup>146</sup> He was the one who ultimately drafted the order later that evening.<sup>147</sup> At no time did he even contemplate making an order that would stop the rescue.<sup>148</sup> He agreed that it was Mr. Jeffreys who spoke about the order from the MOL. He did not know, however, what order Mr. Jeffreys was referring to.<sup>149</sup>

It is difficult to reconcile Mr. Jeffreys's statement that, at the CCG meeting, he made it clear that the proposed order would have no effect on the rescue or recovery efforts when some attendees clearly understood the opposite. Suffice it to say that his efforts at clarity failed. However, the fact that some – including a number of decision-makers within the CCG – thought the order prevented any rescue efforts from continuing did not change the reality of the situation. There was never an order that interfered in any way with the rescue. More specifically, as Staff Insp. Needles said, the MOL did not shut down the rescue.

It seems that – even within the MOL itself – there was unclear and imprecise language used in connection with the order that the ministry would issue in respect of the Mall. At 5:24 p.m., Mr. Jeffreys requested that Mr. Sanders send an email to Gabriel Mansour, the MOL provincial coordinator and also a structural engineer, to provide him with an update. After summarizing the load calculations that Mr. Cranford had made about the precariousness of the overstressed beam, Mr. Sanders wrote the following:

HUSAR has pulled all of their team out of the collapse area and are not planning to send them back in. No one is in the building at this time Roger and I have had numerous meetings on site with the HUSAR staff, especially with James Cranford, their structural engineer, and Tony Comella in regards to the safety of all on site.

In respect to the rest of the building, there are numerous signs of rust and fatigue throughout the building (many reports and indications of water damage), hence our determination in shutting down the whole facility until an engineer can determine that it is safe to be in, or determines complete demolition of the structure. Either way, a report from an engineer will be required before we will let them proceed further.<sup>150</sup>

A plain reading of this email would indicate that Mr. Sanders was under the impression that the MOL was preventing the HUSAR/TF3 forces from proceeding further. However, in his examination by Commission counsel, Mr. Sanders explained it differently:

Q. ... Who was the “them” you were writing about in the last sentence?

A. As I indicated earlier, that’s the owner. The order that did get written was to the owner as all orders get written.

...

Q. – you’ll agree with me that nowhere in your letter do you make any reference to the owner?

A. That’s correct.

Q. And what you reference to, in terms of workers, is the HUSAR workers. And particularly, in the – fourth last line in the third paragraph you write: “HUSAR has pulled all of their team out of the collapse area and are not planning to send them back in.” And then in the next paragraph you write: “Either way, a report from an engineer will be required before we will let them proceed further.” But it’s your evidence that the “them” in the fourth paragraph is referring to the owner, not to the HUSAR people?

A. That’s correct.

Q. And did you ever hear any discussion before you wrote this letter, about the Ministry of Labour issuing an order which would prohibit anybody from entering the entire site?

A. I did not, no. That never – never came up.

...

Q. But my question to you, sir, was: When Mr. Jeffreys spoke to you and told you what you needed to know to write this letter, did he say that the order that Mr. Jones was going to issue was going to apply to everybody or that it was going to apply to –

A. He –

Q. – everybody except the rescue or recovery workers?

A. He didn’t indicate. He didn’t – he didn’t – he didn’t say. He just said that a requirement order would be issued on the remainder of the building. So ...

Q. Did he say “on the remainder of the building”?

A. Just as I wrote here, “in respect to the rest of the building,” he said on the remainder of the buildings from what we had seen.



Q. Did he mention anything about whether the order that was going to be written would apply to rescue or recovery workers?

A. No.

Q. And it was your understanding at the time, as you've told us, that the Ministry of Labour powers existed even in respect of workers undertaking a rescue; right?

A. That's correct.<sup>151</sup>

The lack of clarity evident even in the MOL's internal communications reflects the more widespread confusion and uncertainty which affected many people's perceptions of the reason the rescue was called off – and the MOL's role in it.

## The decision to stop the rescue is communicated

### To the families – in a less-than-sensitive manner

It was agreed at the CCG meeting that Mayor Hamilton, Insp. Jollymore, and Staff Insp. Neadles would go to the Collins Hall to notify the families that the rescue was over.<sup>152</sup> Taking this step was yet further indication that, at that point, the response leaders considered that the rescue operation was at an end.

Insp. Jollymore had given an update to the families earlier in the afternoon at the Collins Hall. He indicated that he would be back around 4:30 p.m. to provide a further update. After the earlier update, Mr. Latulippe went home to have a shower. He had just gotten out when he received a phone call from his wife, who said he had to come back to the Hall, which he promptly did.<sup>153</sup>

Teresa Perizzolo had remained behind when Mr. Latulippe, as well as the Aylwin family, had left the Hall to get cleaned up. In their absence, she received the news that the rescue was over. She testified that Staff Insp. Neadles told her: "It is not a recovery anymore; it has now become a demo. We're going to demo the Mall and that's the way we're going to recover the bodies." Staff Insp. Neadles and Insp. Jollymore started to leave the area. She collapsed to the floor.<sup>154</sup>

Mr. Latulippe went straight to his wife when he got to the Collins Hall. She implored him to do something, saying, "You have to do something to make them stop." She told him that they were giving up.<sup>155</sup> He left Ms. Perizzolo. He saw and heard Mrs. Aylwin scream and collapse into a chair. Both he and Mr. Aylwin approached Staff Insp. Neadles and Insp. Jollymore looking for answers. Staff Insp. Neadles said that the Mall was going to be turned over to the owner and that they were leaving. Mr. Latulippe recalled him saying, "We have to turn the Mall over to the Mall owner. He has to get an MOL-approved demolition recovery team. They're going to knock the Mall down and try to find the remains." Staff Insp. Neadles acknowledged that there were still signs of life but the building was too unstable. Mr. Latulippe and Mr. Aylwin both offered to sign whatever was needed to let them go in to get the victims out. They were told that was not an option. Mr. Aylwin suggested mine rescuers could go in. He was told no one was going in. With that, Staff Insp. Neadles and Insp. Jollymore left.<sup>156</sup>

In the discussion, which became a heated argument, Mr. Latulippe and Mr. Aylwin had tried to tell them the victims were still alive but they did not seem to care. At this point, Mr. Latulippe and Mr. Aylwin refused to accept that the rescuers were just going to leave the victims there and that there was only one way to get them out.<sup>157</sup> Mr. Aylwin testified that the mayor, Insp. Jollymore, and Staff Insp. Neadles were present when he and Mr. Latulippe were told "they were stopping the search because the building was unsafe and they were packing up and going home."<sup>158</sup> Mr. Latulippe and Mr. Aylwin both testified that there was no alternative plan. The rescue, they were told, was finished.<sup>159</sup>

Mrs. Aylwin testified that she, her husband, and her son came back to the Collins Hall after Gary Gendron, her daughter's fiancé, called asking them to come back quickly as there had been some changes to their understanding of the status of the rescue operation. As she entered the Hall, a woman offered her condolences to Mrs. Aylwin. The announcement about stopping had already been made in their absence.<sup>160</sup>

Given that a number of the victims' family members were absent from the Collins Hall when Staff Insp. Neadles, Mayor Hamilton, and Insp. Jollymore arrived there, it would appear that no one thought to call the Collins Hall to ensure that the family members were actually there to receive this tragic news.

Staff Insp. Neadles acknowledged that he told the families that the rescue was over. When he said it was over, that is what he believed.<sup>161</sup> He agreed that he said the rescue was over but denied telling Ms. Perizzolo that the building was going to be torn down or demolished to dig the victims out. He explained that he did not believe that at that time he knew the building would be torn down and the bodies recovered in that way.

However, the minutes of the 3:00 p.m. CCG meeting confirm that these very issues were discussed. The notes record "Recovery will not proceed until owner provides structural engineering report indicating how to safely take down the bld to recover. Will request one week."<sup>162</sup> In addition, Staff Insp. Neadles spoke at the press conference shortly after this conversation and stated that a demolition company would be involved in the recovery of bodies. Consequently, his rationale for denying the use of those words to the families is not convincing. I accept that he did tell Ms. Perizzolo about demolition being the process that would recover the bodies. I find further support for this when I consider that he could not deny having told Mr. Latulippe words to the effect that the building would be torn down and that is how bodies would be recovered.<sup>163</sup>

Staff Insp. Neadles was unable to deny that he told Mr. Aylwin that they were packing up and going home. He said only that he did not believe that he said those words. I accept that he did give Mr. Aylwin that very message. By this point, since he had turned the operation over to the Elliot Lake Fire Department, there would not appear to be any further need for HUSAR/TF3. As well, Staff Insp. Neadles acknowledged that he had no authority to continue if it was going to be a demolition. To stay on, he would need further approval.<sup>164</sup> I am inclined to the view that, as things appeared to him at that time, he thought that HUSAR/TF3 would be packing up and going home.

Insp. Jollymore said that he travelled to the Collins Hall with the mayor<sup>165</sup> and would have met Staff Insp. Neadles there.<sup>166</sup> He believed that the families were not notified in advance of the group's attendance. On arrival, he was informed that some family members were present, others were not. The news was given to those present and they waited for five to 10 minutes for more family to show up and then repeated the news to newcomers.<sup>167</sup> Insp. Jollymore did not know the identities of the family members so he had asked that they identify themselves before he spoke with them.<sup>168</sup>

Mayor Hamilton stated that he had asked Staff Insp. Neadles to attend so that the families would be able to have their specific questions answered.<sup>169</sup> He acknowledged that addressing the families when members were missing was not the best decision.<sup>170</sup>

Ms. Kerr testified that the families were given this information in the same room as members of the general public. She had been asked by Staff Sgt. Dan Esposto of the OPP to have a room available in which police could speak to the family privately, but there was no room which would have accommodated all the family members. This was unfortunate because it required these people to learn of the fate of their loved ones in a public forum.<sup>171</sup>

**Given that a number of the victims' family members were absent from the Collins Hall when Staff Insp. Neadles, Mayor Hamilton, and Insp. Jollymore arrived there, it would appear that no one thought to call the Collins Hall to ensure that the family members were actually there to receive this tragic news.**

## To the OPP UCRT members – with an expression of frustration

As previously mentioned, Sgt. Gillespie had been told at about 1:30 p.m. that the MOL had stopped the rescue on account of the instability of the building.<sup>172</sup> He had gone back to his hotel to sleep and he returned to the site at about 4 p.m.<sup>173</sup> He said that a debriefing of most of the HUSAR/TF3 team was taking place in the command tent. He stood at the doorway and listened. He learned that HUSAR/TF3 would be leaving shortly. He heard some members objecting to the fact that the rescue was over.<sup>174</sup>

He returned to the Hampton Inn and briefed his men just before 5 p.m. He told them what he had learned at 1:30 p.m. and the information he had overheard at the debrief shortly before. He said that he had been advised by Cmdr. McCallion that the MOL had made an order at 1:15 p.m. that day, prohibiting entry to the building due to the overloading of the beam under the escalator; he believed that no further rescue operations would be allowed and that no efforts by either HUSAR/TF3 or UCRT would be permitted. He said that Capt. Comella had advised him that the beam was 468 percent overloaded and should have failed already.<sup>175</sup> His notes of this briefing contain the following:

No OPP incident command throughout this entire event visible at the scene. Not personally observed OPP IC Percy Jollymore since arrival of my crew at this location. Operating under this command of TF3 – No S/Sgt – or FSB [Field Support Bureau] inspector here – I am running OPP UCRT tactical operations and cannot do this at night shift and attend day command meetings. I trust that what their command is effectively running this tactical portion of the incident and I and my crew are under their direction. I made the decision to abide by this chain of command as there is no other at this time. I heatedly objected to these decisions but respect chain of command. Advised my crew of this at the parking lot of Hampton [Inn]. Advised to eat and attend site for further direction but that TF3 is leaving post dinner.<sup>176</sup>

His crew was upset at the news that the rescue was over. He compared the sense of deflation they felt to tripping and falling 100 metres short of the finish line in a marathon.<sup>177</sup>

In his evidence, Sgt. Gillespie stated that the reference in his notes that he “heatedly objected to these decisions” did not refer to the decision to stop the rescue but rather to Cmdr. McCallion’s accusations that the rigging was carried out in an unsafe manner.<sup>178</sup> I have difficulty accepting anything except the plain meaning emanating from his notes. They clearly record his frustration at having to accept direction from HUSAR/TF3 in circumstances where there has been no input from the OPP.

## To the public – the 5 p.m. press conference

At 5 p.m., the public was informed that the rescue effort was over. Staff Insp. Neadles gave the following reason for stopping the rescue:

So what the engineer believed would be, when that escalator fall [*sic*], the beams would come down with it. We don’t know, can’t say, it might bring the exterior down, but what may have been attached to that beam, may have brought the interior structure down, putting the workers at risk. Um, it was a position, um, that unfortunately I am able to make and, therefore, I had to remove the members of the team and the OPP from the structure.<sup>179</sup>

He continued his statement by explaining what he expected to happen as a consequence of stopping the rescue:

Having done that, uh, that then turns the facility back to the local authorities and, uh, and that’s when the Ministry of Labour becomes actively involved in the position and the Ministry of Labour then, will now put an order on the building for that the owner must now hire an engineering firm to come up with a, a plan that’s approved by the Ministry to, uh, to des-, have the destruction of that area, taking into



consideration that there are still two bodies in that building. Um, the demolition company that may, may, that would be hired certainly would have to put into the plan on how they would deal with the integrity of a very respectful removal of the deceased that are within that building currently.<sup>180</sup>

He explained that he was not able to use either the dogs or the OPP LifeLocator to determine if there were still signs of life. To do either would involve risking the lives of searchers because of the precarious state of the building.<sup>181</sup> He concluded his statement by saying:

So, um, our team is, is certainly not happy. I'm not happy. Nobody is happy that we have to, have to stop work, but that's unfortunate, unfortunately the way that we've had to, we've had to end this situation. Now, um, uh, I have turned, from what my position is, I've turned the, the, uh, scene back over to the local authorities to now go forward.<sup>182</sup>

During the question and answer portion of the press conference, the following exchange took place:

Al Sweeney: Hi, Al Sweeney from CHCH in Hamilton. Um, I just want to get it clear that the OPP found sounds of life in the building this morning. What's happened to that person? Can you say?

Bill [Neadles]: Um, that person is still there. We, I don't know the condition of that individual.

Al Sweeney: But you, but you feel you have to call off the search now, uh, because of the safety issues?

Bill [Neadles]: Because of the safety, yes.<sup>183</sup>

This exchange made it clear that the search was being called off with the knowledge that there may still be a living person in the pile. This fact was certainly not lost on those in attendance, as the following statement illustrates:

My name is Carol Finch. And I do not know the people that are still in there, but I want to know how are we going to deal with the one that may still be alive? Um, what are we going to do? We can't just let them die. We need some sort of, and I do understand, yes, that the building is compromised and we can't afford to lose anybody else, but no one has spoken to the one that may still be alive.<sup>184</sup>

Staff Insp. Neadles's response was a frank admission of defeat:

I, I understand that it's, it's not an easy process, and let me tell you, it's not an easy decision. I don't have the wherewithal to go any further on the rescue mission. Um, neither I have the training nor the equipment, even if it was brought in, the integrity of the building would not allow a safe, direct access to it. I really can't give you the answer you're looking for other than to say we are unable to continue and, respectfully, that is the only legal option that I have.<sup>185</sup>

Further, another member of the public implored: "If there is a possibility that there is one person living, we cannot let them lay there and die!" This same member of the public raised the possibility that Ontario Mine Rescue might be able to do the job that HUSAR/TF3 could not.

Later on, Mayor Hamilton, Mr. deBortoli, and Chief Officer all said that following the press conference the local authorities could meet to discuss options. However, none had any concrete ideas at that point. In answer to a question from a member of the public about whether the City would look into all possible solutions, including Mine Rescue, Mr. deBortoli said:

Yes, we will ... explore all available options. ... [O]bviously we are not, not, uh prepared to quit on this either. ... [B]ut again, as Mr. Neadles has referred to, there are, there are certain limits and legalities that we have to be respectful of and ... you know we can't ... be putting more lives at risk unnecessarily...<sup>186</sup>

The public, as might be expected, was outraged at the news.

## The community reacts with frustration

Following the conclusion of the 5:00 p.m. press conference, the community of Elliot Lake reacted with understandable frustration at what it had been told. A crowd of people, which seemed to grow rapidly, gathered outside city hall and around the Mall perimeter shortly after the press conference. As described by Mr. deBortoli, the townspeople had the impression “things were coming to an end” and they were not happy about it.<sup>187</sup>

MPP Michael Mantha did not attend the 5:00 p.m. press conference. He had remained in the vicinity of city hall with 70 or 80 community members. After the news from the conference filtered out, the townspeople reacted with outrage. Mr. Mantha described the scene:

What happened is I remained in behind which would be the City building, and there was a large group of people that were – that had gathered there, and I am not sure how to explain this other than you – it was so toxic, the environment that was going on there, because of the announce [*sic*] to cancel the rescue efforts. There was no other way that I can describe that as toxic. I – it concerned me, but I knew that it had to be – we had to deal with it because what I was seeing is community members that were willing to take matters into their own hands. And I was concerned that we were going to get a group of individuals that were actually going to rush the barricades that were there and go into the mall and get that family member.<sup>188</sup>

Mr. Mantha further described that some of the townspeople were attempting to offer waivers of liability to entice the government or OPP to allow them to access the site:

It had come to a point where they were starting to write petitions and prepare release forms, releasing the government of any responsibilities or the OPP for permitting them to go onto the site. It was very concerning, and just the amount of frustration that was there really, really scared me that more community members were going to put themselves potentially in harm's way.<sup>189</sup>

Mr. Mantha advised Mayor Hamilton that there needed to be increased police presence at the Mall to control the crowds that were forming.<sup>190</sup>

Mr. Latulippe described the attitude of the people that had gathered around the Mall as being “irate.” He remembered that people were shouting, “Don’t let them die. Don’t let them die.”<sup>191</sup> Mr. Gendron described the community as “devastated” by the news that the rescue had been called off.<sup>192</sup>

After the press conference, Sgt. Fowlds noticed a group of people approaching the Mall looking upset.<sup>193</sup> He described one of the men in the group as looking distressed. Sgt. Fowlds approached the group to show that the rescuers were also upset at not being able to continue the rescue:

I could – walking towards him, I could see the veins in his neck bulging, and he was constantly making fists. With just the rest of the policing experience I have, that’s not a good sign. I approached the group. There was some other people who were with me from the task force. I’m not sure who they were. I had conversations with him. He was still upset, but he ended up walking away yelling and screaming at us. One of the ladies that was in the group came up to me and she said – and I’ll change her wording a bit. She basically said we didn’t care. We don’t – there’s nothing – we’re just there because we don’t care. I was wearing my sunglasses at the time. I took my sunglasses off and told her look in my eyes and tell me I didn’t care. I have no problem admitting I was crying at the time. I didn’t like the fact that we weren’t allowed in the building, and we had to stop what we were doing. Our idea was to go in and do our job, finish what we started, and hopefully come out with a good result at the end.<sup>194</sup>

Insp. Jollymore reinforced the OPP presence at the perimeter of the Mall. He testified that his strategy was to engage in a dialogue with the crowd to disarm the situation as best he could:

I wanted the people to engage the crowd, to speak to them, to tell them we were doing the best we can at resolving this issue, and I wanted a dialogue. If we – I felt that they were upset, but they had the right to be upset. I just didn't want anybody hurt ...<sup>195</sup>

The local OPP forces called on the UCRT members to assist with maintaining public order.<sup>196</sup> At 6:00 p.m., Sgt. Gillespie, now back at the Mall, updated his superior with the information that “there is a protest of the decision to stop working.”<sup>197</sup> The townspeople were gathering in the parking lot outside the OPP detachment, all along Ontario Street, and even in the wooded area to the west of the Mall.<sup>198</sup> The throng of people was so large that it seemed to Cst. Dan Bailey that “all the concerned people of the town had congregated” around the Mall.<sup>199</sup>

Capt. Guy observed that some members of the crowd appeared very angry and were chanting at the rescue workers. He had not witnessed anything like that before.<sup>200</sup> He testified that, at one point, Ms. Aylwin's father came up and expressed his concern about why the teams were not still attempting to rescue victims. He explained to Ms. Aylwin's father that he has children who expect him to come home also and that although the rescuers wanted to get in there and do the work, right now they were not allowed to. Ms. Aylwin's father shook his hand and thanked him and asked him to just try to get back in to continue the rescue.<sup>201</sup>

At approximately 8:00 or 8:30 p.m., Ms. Kerr from Victim Services of Algoma contacted the OPP but was unable to speak to anyone in Elliot Lake. She then contacted city hall and was advised by Ms. Bray that there was an angry crowd outside city hall and the Mall and they were concerned that the crowd might move to the Collins Hall. There were concerns for the safety of the workers at the Mall. She was instructed to close the Hall for safety reasons. Ms. Kerr (with the assistance of City of Elliot Lake staff) shut down the Collins Hall at 9:00 p.m. No one from the general public was in the Hall at the time it closed.<sup>202</sup>

At approximately 9:09 p.m., members of the OPP detachment became aware of a possible “attack” on city hall to create a diversion for members of the community to enter the collapsed area and continue the rescue operation. The detachment asked the UCRT team what resources it could provide to create a perimeter defence around the building.<sup>203</sup> The UCRT team had in fact been deployed to assist with scene security around the Mall and public order duty at 7:00 p.m. This duty continued until 2:00 a.m. on June 26.<sup>204</sup>

Ultimately, the townspeople of Elliot Lake did not storm the Mall. The OPP did not have to arrest anyone that evening at the Mall.<sup>205</sup> The community reacted to the heart-wrenching news that the rescue had been stopped with a sense of outrage that was not unreasonable in the circumstances. Indeed, just hours before being told that the rescue was over – in the most recent update from the rescue leaders – the townspeople had been publicly advised of recent signs of life in the collapse zone. To be told in the next press conference that the rescue was ended came as shocking news to everybody – Elliot Lakers and outsiders alike.

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## After the cancellation of the rescue, options appear limited

With the rescue called off, major problems emerged for the City of Elliot Lake and other organizations still involved in the response. Not the least of these was that there was a manifestly hazardous shopping mall with victims trapped in it, one of whom was thought to be possibly alive. Unresolved questions included: how to access the victims, and how to deal with the unsafe building? These problems must have seemed all the more daunting considering the province's only heavy urban search and rescue team was about to leave town – apparently having run out of options.

Following the press conference, a group of key officials had an ad hoc meeting in a room in the Elliot Lake OPP detachment.<sup>206</sup> The meeting included the following attendees:<sup>207</sup>

- Robert deBortoli and Bruce Ewald from the City of Elliot Lake;
- Fire Chief Paul Officer;
- Roger Jeffreys, Brian Sanders, and Donald Jones from the Ministry of Labour;
- Dave Howse from the Office of the Fire Marshal;
- Henry Alamenciak from Algoma Emergency Medical Services;
- Dr. Craig Muir, the regional coroner; and
- Det. Sgt. Ed Pellerin and Sgt. Adam Oprici from the OPP.

The primary purpose of the meeting was to answer the questions: who has the authority to tear down part of the Mall structure and how could the victims be removed in a dignified manner?<sup>208</sup> Mr. Jeffreys described the meeting as an attempt to address the problems associated with trying to access bodies on private property.<sup>209</sup> The group considered how to undertake a “controlled demolition” of the remaining structure.<sup>210</sup> The answers were far from clear – with each of the organizations appearing to lack direct authority to act in the circumstances.

Someone suggested that the MOL could issue an order requiring the City to tear the building down. Mr. Jeffreys advised the attendees that ordering demolition of a building was not in the MOL's mandate. He said: “[W]e just cannot order anybody to tear anything down. We don't order demolition. That's not us.”<sup>211</sup>

Mr. Jeffreys then suggested that the coroner must have such authority. Dr. Muir replied that he was not aware of anything under the coroner's governing legislation that would give such authority.<sup>212</sup>

Mr. Ewald added that the City of Elliot Lake would have the authority to undertake the demolition of the building only if there was an emergency that was threatening human life. As the operating presumption at the time was that the victims trapped in the Mall were deceased, the City consequently lacked the authority.<sup>213</sup>

Mr. Howse offered that the Office of the Fire Marshal would, similarly, only have the authority in the event of a threat to life or fire safety emergency. In his view, those conditions were not present.<sup>214</sup>

As a result of those exchanges, the group was – to use Mr. Jeffreys's characterization – “at an impasse” as to how to proceed.<sup>215</sup> As described by Chief Officer, the group seemed to be frustrated by the “legal minutia” of attempting to move the operation forward.<sup>216</sup> Mr. Jeffreys indicated to the group that, from his perspective, “it looks like the one party that can move it forward is the owner, and the owner isn't sitting at the table here.”<sup>217</sup>

The meeting ended without any decision or plan. At 6:15 p.m., there was a CCG meeting. The meeting opened with a comment that townspeople were “trying to crash the line” and that security would be “amped up” for the evening.<sup>218</sup> Later in the meeting, according to the meeting notes, the members of the CCG discussed, in general terms, options for dealing with the fatally compromised Mall. The following are comments attributed to

Mr. deBortoli: “work within the framework we have to do what we can to expeditiously as possible. Sequential approach to dismantling a portion of the mall as per engineer. Must work with the owner.”<sup>219</sup>

The question about who would have the authority to undertake a controlled demolition of the building to access the victims was considered again at a meeting of the CCG at 8:30 p.m. Ultimately, it was never resolved – it was moot after the operation resumed following the intervention of the premier of the province. I discuss these events in the next chapter of this Report.

## Sgt. Phil Glavin raises with Staff Insp. Neadles the prospect of using Priestly

Sgt. Phil Glavin came back on duty at 6:00 p.m. unaware that the rescue had been called off. When he returned to the Mall, he was briefed by a superior officer within HUSAR/TF3 that the rescue was in a “full stop because it was unsafe.”<sup>220</sup> Sgt. Glavin was tasked with assembling a HUSAR/TF3 command tent and erecting lighting on the parking level that was closest to the main entrance of the Mall. Shortly thereafter, he went to a nearby church basement where dinner was being provided to HUSAR/TF3 team members – but Sgt. Glavin went to the church with a different objective in mind:

- A. I remember as soon as I got to the church I was on the hunt for Neadles.
- Q. And I gather you saw him there.
- A. Yes, I did.
- Q. And why don't you tell us about your conversation with him.
- A. I saw him. Everybody – emotions were running pretty high. There was a lot of teary eyes. Everyone was very upset because we – we wanted to continue working. I see, you know, my boss who I've known for a million years, I go up to him and I go, “I've got Plan B.” And he goes, “Pardon?” And I said, “I've got another plan.” And he goes, like, “Where were you two hours ago?” So we start talking and I start describing, with my arm up in the air, how this machine – the Priestly machine can reach and grab and surgically remove. And he – he's, you know, motioning me, keep on talking to me, keep on painting your picture, Philip, and I do. I tell him that, you know, this – it can sit far enough back from the building without causing any more vibration. It's got an extendable boom so it can reach out. It's got a surgical tip on the end of it, if you want to call it that, where it can pick up or it can nibble or it can sheer. And I said, “Boss, this is – we're now here. We need this piece of equipment.”
- Q. How did you know what the issue was? Like how did you know that the – what the reason for the stoppage was?
- A. We were told it was unsafe for us to be in there.
- Q. Right. But that can cover all sorts of things.
- A. Yes, it could. If it was because of secondary collapse, because the building was – because I knew the building was moving...
- Q. Did Staff Inspector Neadles... articulate what the problem was during your discussion at the church hall?
- A. I – I'm almost positive he said it was the secondary collapse. We're afraid of the mall coming in on top of the rescuers.
- Q. And did he isolate it more so that you knew specifically that the problem related to the beam that was supporting the escalator and the core slabs?
- A. The – the fear was that the escalator was going to slide forward; and if it came forward, that would have been on top of our second victim.<sup>221</sup>

According to Staff Insp. Neadles, this information from Sgt. Glavin was “the first indication, real indication of a go-forward plan.”<sup>222</sup> He testified that Sgt. Glavin explained that the Priestly operation had a piece of equipment which was equipped with a long articulating arm that could “potentially rectify the issue with the staircase and the slab of concrete that were on top of it.”<sup>223</sup>

Staff Insp. Neadles instructed Sgt. Glavin to explore the viability of using the Priestly operation in Elliot Lake.<sup>224</sup> Sgt. Glavin made a notation that he was “to lean forward re. options.”<sup>225</sup> He testified that this meant he was to explore options related to Mr. Priestly – but that he should “not spend a dime” in doing so.<sup>226</sup>

Sgt. Glavin tried to reach Mr. Priestly but was unable to speak to him until 8 p.m. As I will explain in the next chapter, consideration of using Priestly Demolition at the collapse scene did not advance in any significant way until after Staff Insp. Neadles had spoken to the premier at about 8:30 p.m. that evening.

## HUSAR/TF3 prepares to leave

### Staff Insp. Neadles tells his members they are going home

After he left the press conference, Staff Insp. Neadles briefed the members of HUSAR/TF3 at approximately 6:30 p.m. He advised the team that the Mall was too dangerous to send rescuers in.<sup>227</sup>

As previously mentioned, Sgt. Gillespie was standing at the entrance to the command tent and overheard the briefing. He recalled Staff Insp. Neadles stating that the decision had been made that it was too dangerous to continue the rescue and “the decision to pack up and leave was being made.”<sup>228</sup> Sgt. Gillespie was so convinced that the rescue was called off that he requested permission to stand down altogether and return to Bolton. His view was that “if there was nothing for us to do then there is no point in us being there.”<sup>229</sup> This request was denied.<sup>230</sup>

Staff Insp. Neadles could not recall whether he indicated that HUSAR/TF3 would be leaving Elliot Lake. He testified:

I might have said we were going home, but realistically with the Control Group going back to come up with their options, I knew I was going to wait until there was something either yes or no from them and I was then going to go and speak with some of my senior folks, Tony Comella and some others who may have been able to in that time formulate something.<sup>231</sup>

In view of my earlier conclusion that Staff Insp. Neadles did not have a “Plan B” in mind when he called off the rescue, I am of the view that he likely told his forces that HUSAR/TF3 would, in fact, be preparing to depart Elliot Lake. Sgt. Gillespie had a clear recollection of this fact, and Staff Insp. Neadles did not dispute that he might have said it.\*

### Key personnel are sent packing

Capt. Comella told Mr. Cranford that he was no longer needed. At 7:15, Mr. Cranford and Dr. Feldman left together to drive back to Toronto. Later, I will describe Mr. Cranford’s offer to return to Elliot Lake.<sup>232</sup>

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\* There is a discrepancy with respect to the timing of when Staff Insp. Neadles may have briefed his forces about HUSAR/TF3 departing Elliot Lake. As I noted earlier, Sgt. Gillespie noted that he overheard Staff Insp. Neadles make this comment at a debriefing before 5:00 p.m. Staff Insp. Neadles and Mr. Cranford recalled a debriefing that took place after the 5:00 p.m. press conference. The exact timing of this briefing is, therefore, difficult to pin down. Nevertheless, this does not move me away from the conclusion that the comment was made after the stoppage of the rescue.



## MPP Michael Mantha threatens to chain himself to the HUSAR/TF3 bus

Mr. Mantha had a discussion with Staff Insp. Neadles between 7 and 8 p.m. that left him with the clear impression that HUSAR/TF3 would soon be departing Elliot Lake. Staff Insp. Neadles indicated it could take seven to 14 days to access the bodies of the victims.<sup>233</sup> Mr. Mantha testified:

I noticed that Mr. Neadles was there, and I asked him, "Can we have a discussion? I need to understand what is going on here." So I brought him outside, and I asked him, "What is going on? What is happening?" And he explained to me that, essentially, the decision had been made to halt the rescue efforts; that he had reached his mandate, or their group had reached their mandate. He made it a point to be very clear with me. He says, "Listen, these guys live for these types of things. It is not something that they wanted to do is to withdraw them from there. It is just – it is too unstable for us to proceed with any type of rescue effort right now at this point in time." And that they were – that they could not continue in a safe manner ... And it is at that point in time that he had informed me that the decision that had been reached was a joint decision between the Ministry of Labour, who had their own engineers, along with HUSAR, who had engineers. And it was a joint decision that was reached where they couldn't safely do the rescue efforts. I said, "You need to understand how toxic that environment is there." And I said, what is happening? So what is going to happen with you?" "Well, we are still looking. We are still talking with the Fire Department as far as assessing what could be done or what can be done," he said. "But right now, we are in a stand-down position, and we are preparing – we are starting to pack our equipment." I said, "Well, how much time do I have? Like, when are you leaving?" I said, "You need – you really need to understand how bad this environment is." I said, "There is no way in hell" – I apologize about that – "there is no way that you are going to be leaving. If there is anybody that is going to pull those family members out, it has to be you guys. You need to understand the environment and the toxic environment that has been created in this community over the years with this particular mall and the mall owner. It can't be a blue crew. It can't be a pink crew that comes in there. It has to be you guys, and you guys have to get back in there. And there is no way in – there is no way that I am going to let you guys leave this town. I'm going to chain myself in front of your bus."<sup>234</sup>

The notion that HUSAR/TF3 expressly contemplated leaving Elliot Lake altogether is troubling. It demonstrates the depth of its failure even to consider an alternative plan of action. It also left the leaders of Elliot Lake with the highly unenviable prospect of having to consider their next options without the benefit of the province's leading heavy urban search and rescue expertise.

As I will explain in the next chapter, the decision to call off the rescue was reversed after the premier and senior provincial officials spoke with Staff Insp. Neadles and urged him to consider other options.

## Notes

- <sup>1</sup> Cranford testimony, September 9, 2013, pp. 24801–2; Exhibit No. 7545.
- <sup>2</sup> Comella testimony, September 5, 2013, p. 24233; McRae testimony, September 25, 2013, p. 27247.
- <sup>3</sup> Guy testimony, September 24, 2013, pp. 27119–20; Comella testimony, September 5, 2013, pp. 24243–4.
- <sup>4</sup> Cranford testimony, September 9, 2013, pp. 24801–6.
- <sup>5</sup> Cranford testimony, September 9, 2013, pp. 24806–8.
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- <sup>7</sup> Gillespie testimony, September 3, 2013, pp. 23888–9.
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- <sup>9</sup> McCallion testimony, September 6, 2013, pp. 24573–6.
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## Political intervention was essential to the resumption of the rescue / recovery

As I discuss in the first part of this chapter, the involvement of the Premier's Office was essential to the resumption of the rescue / recovery efforts at the Algo Mall.\* In order to understand the context in which the premier and his staff reacted to the events, it is important to understand what information they had obtained before the evening of June 25. The inadequate flow of information from the people on the ground to senior officials is relevant to this discussion. Therefore, at the risk of repeating myself, I return to the time of the collapse and I review some key events from the perspective of Premier Dalton McGuinty and his staff.

Two witnesses with direct knowledge of the involvement of the Premier's Office gave evidence: Mr. McGuinty, former premier of Ontario, and John O'Leary, former manager of legislative issues in the Premier's Office.

Mr. McGuinty became the premier of Ontario in 2003 and held that position until 2013. During that decade, he attended other emergencies, including a flood in Peterborough, the tornado in Goderich and Leamington, forest fires in Northern Ontario, and the explosion of a propane facility in Toronto.<sup>1</sup> When he gave evidence in October 2013, he was a fellow at the Weatherhead Center for International Affairs at Harvard University.<sup>2</sup>

Mr. O'Leary holds a bachelor of arts degree in history from Queen's University. After graduating, he worked as a staffer for Cabinet ministers Gerard Kennedy and Kathleen Wynne. Mr. O'Leary joined Premier McGuinty's office in December 2007 as his special assistant for issues management and legislative affairs. At the time of the collapse, Mr. O'Leary was the manager of legislative issues.<sup>3</sup> Throughout the response to the collapse, Mr. O'Leary took handwritten notes in a notebook,<sup>4</sup> which are found at Exhibit 9139.<sup>†</sup> A typed version can also be found at Exhibit 9140.<sup>‡</sup>

I accept the evidence of Mr. McGuinty and Mr. O'Leary without reservations. I also heard from Michael Mantha, the MPP for the riding of Algoma-Manitoulin, which includes the City of Elliot Lake. Mr. Mantha was first elected in October 2011.<sup>5</sup> I accept his evidence as well.

## Key players within the Premier's Office and the Cabinet Office

Approximately 70 people worked in the Premier's Office in June 2012. This office consists exclusively of political staff, as distinct from public servants who work, for example, in the Cabinet Office. The employment of the political staff is at the pleasure and the term of office of the politician they serve.<sup>6</sup>

At that time, David Livingston was Mr. McGuinty's chief of staff, the most senior position in the office. Laura Miller, a deputy chief of staff, was responsible for communications and issues management.<sup>7</sup> Mr. O'Leary reported to her. As manager of legislative issues, he not only coordinated the management of contentious issues through the Premier's Office but liaised and worked with the various ministries as well. His job started at 5:00 a.m. every day with a review of the news media for stories that might affect Ontario, the Government of Ontario, and its operations. Every weekday morning he chaired a conference call with the individuals responsible for issues management in each of the relevant ministers' offices. The purpose of the call was to brief himself and the Premier's Office on contentious issues of concern to the government and its ministries and to ensure that all other ministries were equally informed.<sup>8</sup>

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\* See glossary for definitions of rescue / recovery operations.

† The redactions in the document concern information that is not germane to the purposes of this Inquiry and relate to other issues that Mr. O'Leary dealt with as part of his duties. O'Leary testimony, September 17, 2013, p. 25873.

‡ In the typed version, the asterisks followed by the indication "next page" refer to the page breaks in the original handwritten notes. The solid line drawn below certain portions of written text indicates that the exchange is complete and that the next set of notes refers to another exchange. O'Leary testimony, September 17, 2013, pp. 25874–5.



In the aftermath of the Mall collapse and the response, Mr. O'Leary was responsible for gathering information at the political level about the Elliot Lake response and sharing that information with various ministers' offices. He was appointed early on by Mr. McGuinty as the point person on the Elliot Lake file.<sup>9</sup>

Tracy Sobers was Premier McGuinty's executive assistant. She was the gatekeeper, responsible for his calls and his appointments as well as his outings and any activities he was involved in. Mr. McGuinty agreed that she would often be the funnel through whom information would flow to him. Beckie Codd-Downey was junior to Ms. Sobers. She worked closely with Ms. Sobers and sometimes replaced her in travels with the premier.<sup>10</sup>

Wendy McCann was responsible for communications. She monitored the media and helped draft press releases issued by the Premier's Office. Press secretaries reported to her, and she in turn reported to Ms. Miller.<sup>11</sup>

The Cabinet Office is the Premier's "ministry." It works with the Premier's Office to ensure that a government-wide agenda and a holistic approach to the implementation of government policy are in place. The senior official in the Cabinet Office is the secretary of the Cabinet: Peter Wallace held that position in 2012.<sup>12</sup> Debbie Conrad was an assistant deputy minister responsible for communications in the Cabinet Office.<sup>13</sup>

## June 23 – The Premier's Office is informed unofficially of possible fatalities and trapped persons in the collapse

### 5:36 p.m. – The premier is advised of the collapse: He is eager to obtain more information

Mr. O'Leary first learned of the Mall collapse through an email he received on June 23, at 4:23 p.m., from Greg Flood, an employee at the Ministry of Community Safety and Correctional Services (MCSCS), and which he reviewed shortly before 5:00 p.m.<sup>14</sup> Mr. Flood's email had been sent to a group of government officials to whom the MCSCS disseminated emergency information. Mr. O'Leary responded to Mr. Flood, asking him if he had any further developments to report.<sup>15</sup> He also began to notify other individuals within the government who he believed should be aware of the situation. He sent the email to Ms. Conrad, asking her to check with Emergency Management Ontario (EMO);<sup>16</sup> to the chief of staff (Fahim Kaderdina) and his own counterpart (Bill Killorn) at the Ministry of Labour (MOL);<sup>17</sup> and to several individuals at the Premier's Office, including Ms. Sobers, Ms. McCann, and Mr. Livingston.<sup>18</sup> Mr. O'Leary explained that he forwarded the email to his colleagues at the MOL because, while he understood that this ministry would not be the lead agency in the emergency response, he believed it would play a role in supporting any rescue that was organized. He also understood that the MOL, given its role in workplace safety, was responsible for overseeing matters such as the *Building Code* or performing inspections.<sup>19</sup>

Mr. O'Leary's role was to ask questions about the response, gather information, and ensure that information was being shared among the ministers' offices. He did not provide direction to those making decisions about the response.<sup>20</sup> He learned from Thomas Chanzy, chief of staff to MCSCS minister Madeleine Meilleur, that the local MPP was Mr. Mantha, who was from Elliot Lake.<sup>21</sup>

At 5:05 p.m., Mr. O'Leary sent another email to his colleagues at the Premier's Office, advising them of information he had obtained from an email from Mr. Flood at 5:01 p.m.:

Further update from CSCS. MOL and Cabinet Office are also confirming details and assistance.

Media is reporting incident at 2:19 p.m. Opp can't confirm anyone missing or injured. 2 cars apparently fell through the collapsed hole, which is approx. 30 ft x 50 ft. Media also reporting at least 2 ppl missing.

Urban Search and Rescue team (10 members) and Urban Critical Response team (10 members) has [sic] been deployed.

ETA on teams is approx. 8–9 hours.

Community has declared an emergency declaration.

OFM has a [sic] inspector on-site providing support.<sup>22</sup>

He also informed his colleagues at 5:08 p.m. that the local MPP was Mr. Mantha.<sup>23</sup>

At 5:11 p.m., Mr. O'Leary was informed by Mr. Chanzy that one person was thought to be trapped in the structure and that support from HUSAR/TF3 (Heavy Urban Search and Rescue Task Force 3 operated by the City of Toronto) had been requested.<sup>24</sup>

Mr. O'Leary subsequently learned that Ms. Codd-Downey was with the premier at an Ontario Liberal Party Provincial Council in Sudbury at the time of the collapse.<sup>25</sup> At 5:35 p.m., Mr. O'Leary forwarded to Ms. Codd-Downey the chain of emails he had sent his colleagues at the Premier's Office so she could inform the premier immediately.<sup>26</sup> At 5:36 p.m., Ms. Codd-Downey advised Mr. O'Leary that the premier had been alerted to the incident.<sup>27</sup> Mr. McGuinty testified that although he was informed by Ms. Codd-Downey that there had been a collapse of the Mall in Elliot Lake, the information was sketchy about what had happened and whether there were injuries or deaths.<sup>28</sup>

The premier was very concerned and eager to acquire more information. He knew that in these types of emergencies it was important for him to get reliable information at the outset. He also knew that one of the roles he could play was to speak to the mayor: he hesitated to phone on that Saturday, partly because he did not have any reliable information with which to have a productive conversation, and partly because he did not wish to distract the mayor from the response on the ground. The purpose of his call would really be to offer support, and not to ask him for information. He decided he would speak to the mayor the following day.<sup>29</sup>

At 5:34 p.m., Mr. Kaderdina sent Mr. O'Leary an email, advising: "First responders call in MOL when necessary. Right now, no MOL presence on site. Will let you know if that changes." That was the extent of the information the Premier's Office had at the time about the MOL's involvement.<sup>30</sup>

## **6:08 p.m. – First official EMO notification: Someone is trapped in the collapse, and UCRT is being mobilized**

At 6:08 p.m., the duty operations officer at the Provincial Emergency Operations Centre (PEOC) sent out an email to the people on the EMO Listserv, including Mr. O'Leary.<sup>31</sup> At that point, Mr. O'Leary was not aware who was on the email list other than that it was internal to the government and was meant to inform those who needed either to be involved in or to be aware of the emergency situation. The email incorporated an emergency information notification that had been issued at 5:00 p.m.<sup>32</sup> The notification represented the best information that EMO had about the situation at the time.<sup>33</sup> It stated:

### **Description of Threat / Event:**

At 2012-06-23 1509 the PEOC was advised of a structural collapse that had occurred at approximately 2012-06-23 1415 involving the roof of a three storey shopping mall ('Eastwood Mall') located at 151 Ontario Street in Elliot Lake. At least one person is trapped in the debris. Although other people have been injured, current reports indicate these individuals are mobile and their treatment is within the capacity of local medical services.

### **Source of Reporting:**

- Elliot Lake Fire
- OFM
- OPP

**Current Actions:**

- Local Police, Fire and EMS have responded to the scene.
- The community has declared an emergency and formally requested HUSAR assistance. This request has received Provincial approval.
- OFM EPSD is currently liaising directly with Toronto Fire Service regarding deployment of HUSAR resources in support of this event. Toronto HUSAR deployment plan currently in process. Specific details and ETA to follow.
- OPP UCERT is deploying 10 members and 2 medics from Bolton to Elliot Lake (ETA approximately 2012-06-24 0000)
- OFM is deploying 3 members to the scene (first ETA approximately 2012-06-23 1730).

**Initial Analysis / Assessment**

- All stakeholders are actively engaged in providing an appropriate level of response as quickly as possible.
- The PEOC continues to closely monitor the situation should there be additional requests for Provincial support.<sup>34</sup>

At 6:14 p.m., Mr. O'Leary forwarded this email to his colleagues at the Premier's Office, including Ms. Codd-Downey. He stated: "Update from EMO. Confirmation someone has been trapped in the collapse, opp's [sic] heavy urban search and rescue team is being mobilized and will be deployed."<sup>35</sup> Mr. McGuinty testified that it was very likely that the information would have been passed to him by Ms. Codd-Downey: She received information so she could relay it to him. The premier was aware that the City of Elliot Lake had declared a state of emergency. He did not, however, know the roles in emergencies played by either HUSAR/TF3 or UCRT, the Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team operated by the Ontario Provincial Police (OPP). He knew Ontario had in-house expertise for these kinds of rescue operations, but he was not familiar with the names of the teams or their abbreviations.

This information alerted Mr. McGuinty to the fact that the process in place to respond to an emergency was taking its course. There were protocols and procedures to be followed, and he thought the situation was unfolding as it should. The community had wisely declared an emergency, and it could now avail itself of the expertise, resources, and supports offered by the province from various ministries as well as from emergency rescue bodies such as UCRT and HUSAR/TF3.<sup>36</sup>

**6:41 p.m. – Premier's Office is informed there may be fatalities**

At 6:41 p.m. and 6:48 p.m., Peter Cleary, from the Office of the Minister of Health and Long-Term Care, sent two emails to Mr. O'Leary, Seirge LeBlanc (press secretary and the person responsible for issues management in the Office of the Minister of Community Safety and Correctional Services),<sup>37</sup> and others in which he advised:

**6:41 p.m.**

FYI, roof has collapsed at a mall about 150km from Sudbury.  
 O responded but was released later without transporting any patients.  
 CBC reports that they don't have info on injuries or missing people.  
 The roof that caved is where customers and staff park, cars have fallen through a hole.  
 State of emergency has been declared.<sup>38</sup>

**6:48 p.m.**

Latest – sounds like the [sic] are wounded and the hospital said they're ok to manage so far.  
 Possibly 2 deceased at this point.<sup>39</sup>



Mr. O'Leary confirmed that "O" stood for Ornge, the air ambulance service. Mr. Cleary was sharing the information he had obtained with the Premier's Office.<sup>40</sup> For the first time, Mr. O'Leary heard there might be fatalities.<sup>41</sup> Indeed, Mr. LeBlanc responded to Mr. Cleary at 7:00 p.m., noting that the emergency information notification issued at 5:00 p.m. did not state anything about deaths, and only that one person was trapped under debris. Mr. Cleary replied at 7:14 p.m.:

O[rnge] provided me that intel based on real time communications, so although it isn't anything official (a qualified possibly), its [sic] worth sharing what's going through the back channel air waves (which has been a source of leaks in the past weeks). Your info is way more official!<sup>42</sup>

Mr. O'Leary testified that he agreed with Mr. Cleary that it is important to share information, but that the source and the nature of the information should be identified. Mr. O'Leary also noted that it is important to distinguish between what is confirmed and what is suspected, so the two are not confused and result in misinformation. Mr. O'Leary understood that the minister of health's office was not officially confirming any fatalities.<sup>43</sup>

### **7:40 p.m. – Mr. O'Leary learns of two possible trapped persons and seeks information from the Ministry of Labour about the Mall**

At 7:32 p.m., Mr. Killorn sent the following email to Mr. O'Leary:

Hey John,  
Here is the most recent update we got from staff:  
\*MOL has a Structural Engineer on the way; however, it will take approximately 7 hours to arrive at the scene.  
\*We have not confirmed whether any workers are missing at this time.  
\*The preliminary information we have received at this time indicates the following:  
\*9 unaccounted for  
\*2 people trapped  
\*14 people taken to hospital  
I will send you updates as I receive them.<sup>44</sup>

Mr. O'Leary did not know specifically why the MOL sent a structural engineer on site, but given his understanding that the ministry provided assistance in these kinds of situations, he thought it likely that, through EMO, an engineer had been deployed to assist in some way with the response.<sup>45</sup>

In his reply to Mr. Killorn, Mr. O'Leary asked him to check whether there had been any recent reports or inspections of the Mall or its roof, or any orders against the Mall.<sup>46</sup> Mr. O'Leary explained that he was interested in this information because the MOL may have played a role in inspections or in pursuing complaints. He wanted the MOL to better understand the history of its involvement with the Mall, in case that information became important in the future.<sup>47</sup>

### **Mr. O'Leary informs his colleagues in the Premier's Office of the possibility of two trapped persons in the collapse**

At 7:41 p.m., Mr. O'Leary sent an email to his colleagues at the Premier's Office, sharing the information he had received from the MOL. He cautioned that officials had not confirmed any of the numbers, but that this message was an indication that "this could be quite serious."<sup>48</sup>

Ms. Codd-Downey was also provided with this latest information.<sup>49</sup> At 8:03 p.m., she sent an email to certain members of the Premier's Office, including Ms. Miller, in which she informed them that the premier had instructed that someone should provide him with an update the next morning, including information about the provincial response.<sup>50</sup> Ms. Codd-Downey added that the premier had suggested he should contact the Elliot Lake mayor at some point.<sup>51</sup> Mr. McGuinty testified that he wanted his staff to get the mayor on the phone for him.<sup>52</sup>

Mr. O'Leary was designated as the person to provide that update to the premier.<sup>53</sup> As a result, Mr. O'Leary sent an email to Ms. Conrad at 8:17 p.m., advising her that he would need an update first thing in the morning of any overnight actions and any other developments. Ms. Conrad confirmed she would do so and that neither the OPP nor the local community emergency management coordinator was willing to confirm the numbers of injured and missing. Mr. O'Leary later clarified to Ms. Conrad that he also wanted to obtain a full picture of the provincial response and support, and that he needed the information by 6:00 or 6:30 a.m.<sup>54</sup>

At 8:06 p.m., Ms. Codd-Downey also advised Mr. O'Leary that the premier was "confused" as to what a "mall" meant. Mr. McGuinty testified that no one in his office was familiar with the Algo Mall. The question was an attempt to get a better sense of the situation they were dealing with.<sup>55</sup> At this point, Mr. McGuinty saw his role as trying to ensure that the protocols for responding to these kinds of emergencies were being followed. Beyond that, from a political perspective, he saw his role as reaching out to the community and making sure that he understood what was happening to its people. He wanted to respond in a human way and to put a human face to the crisis. In essence, he wished to convey to the people of Elliot Lake that the province was there for them and would find ways to support them. He continued to feel that things were unfolding as they should.<sup>56</sup>

By the end of the day on June 23, Mr. O'Leary knew that there were possibly some fatalities (but he had no confirmation), that a team from the UCRT was on its way to the scene, and that the HUSAR/TF3 team was also making its way to the site.<sup>57</sup>

For the purpose of putting together his report for the premier, Mr. O'Leary relied primarily on the Cabinet Office to supply a comprehensive picture of the supports throughout the government.<sup>58</sup>

## **June 24 – The premier speaks to Mr. Mantha and Mayor Hamilton, and he learns officially of one possible fatality**

### **10:17 a.m. – The premier is updated on the collapse: Although there is no new information, he is reassured that things are unfolding as they should**

On June 24, at 7:56 a.m., consistent with the information he had obtained the previous night,<sup>59</sup> Mr. O'Leary sent an email to his colleagues at the Premier's Office, including Ms. Codd-Downey, in which he provided the following update:

#### **Overview:**

- the roof of Elliot Lake's 3 story shopping mall collapsed
- officials have been unable to confirm number of ppl trapped in the debris, if anyone has been killed, or the number of injured and state of injuries
- opp, emergency mgmt officials and local authorities are meeting today at 8 to update on status and next steps today
- media reported: at least 4 ppl were rushed to hospital, and earlier reports indicated 1-2 ppl were trapped in debris.

Assistance:

- OPP's heavy urban search and rescue team arrived overnight. They are on the scene now and assisting local police, fire, ems. 13 members.
- Toronto Police Heavy Urban Search and Rescue team arrived at 430am and will be assisting as well. It includes 37 officers.
- the Ontario Fire Marshall has sent 3 officials to the scene
- the city is setting up a public info centre, and provincial authorities are ready to assist
- ministry of labour investigators have not yet begun their work, are standing by until emergency operations and any rescues conclude. There has been some speculation that the roof had been leaking and repairs had recently concluded, but we won't know the cause until mol can investigate
- the local Ihin and hospitals were coordinating their care yesterday. Ornge was notified but its services weren't needed.<sup>60</sup>

Mr. O'Leary testified that he believed the MOL would be drawn upon as needed to provide assistance to the emergency responders. He did not consider whether the ministry had the ability to control or stop the way in which the rescue operation was being carried out.

At approximately 10:17 a.m., Mr. O'Leary briefed the premier on the situation. The content of that briefing was consistent with the email he had sent to his colleagues earlier that morning. The information the premier received was essentially no different from what he had been given the day before, except that there were some new specifics about numbers. Mr. McGuinty testified that the information he obtained constituted yet more reassurance that things were unfolding as they should and that personnel, expertise, and resources were being focused on Elliot Lake.<sup>61</sup>

At the same time, the Premier's Office was responding internally to items Premier McGuinty had raised. One item was to get information about Mayor Richard Hamilton from two northern MPPs in order to prepare the premier for his phone call to Elliot Lake's mayor.<sup>62</sup>

At 10:16 a.m., Ms. Conrad sent an email to Mr. O'Leary providing him with the following update:

- Elliot Lake CCG [Community Control Group] meeting has concluded.
- *No identification or confirmation of numbers of potential victims at this point.*
- HUSAR / UCERT currently shoring debris pile to ensure safe entry. Work is being carried out using engineers and MOL oversight.
- Press conference took place at 0900 hours
- Request for refrigeration truck received through coroner's office. Dr. McCallum contacting Regional Coroner (Rick Mann) to discuss details of how and where any potential autopsies would be undertaken. Toronto likely although Sudbury should have capacity.
- Regional Coroner will take care of coordination with OPP and is linked into the PEOC
- Had to reiterate we have NO confirmed numbers.<sup>63</sup> [Emphasis added.]

Mr. O'Leary testified that he understood that the Community Control Group (CCG) included senior emergency response officials such as the fire chief or the chief of police, the mayor, and other members of council who would be involved in leading and coordinating the community-wide response to the situation.<sup>64</sup>



### 11:33 a.m. – The premier speaks to the mayor, advising of provincial support

Mr. O’Leary testified that it took several hours to connect the premier with the mayor.<sup>65</sup> Finally, at 11:31 a.m., Ms. Conrad sent an email to Mr. O’Leary and Ms. Miller advising them that, at 11:35 a.m., the premier could call Bruce Ewald’s mobile phone. Mr. Ewald, Elliot Lake’s chief building official, planned to locate Mayor Hamilton and be by his side at that time.<sup>66</sup>

Mr. McGuinty testified that the purpose of his call was to let Mayor Hamilton know that he had Mr. McGuinty’s support and the support of the provincial government.

Mr. McGuinty testified that the purpose of his call was to let Mayor Hamilton know that he had Mr. McGuinty’s support and the support of the provincial government. Premier McGuinty also wanted to hear about the challenges Mayor Hamilton was facing and to comfort and reassure him that the provincial government was “in his corner.” He told the mayor that he should not hesitate to contact the provincial government if there was something in particular he needed. He asked him how things were going on the ground and how people were managing. He wanted to initiate a dialogue and a relationship – he did not know Mr. Hamilton before this phone call. The mayor did not say he needed anything at that point. He was very concerned about members of the community who might have been trapped

under the rubble. Premier McGuinty had no hard information and very limited knowledge at that time about the human cost.<sup>67</sup>

### 12:28 p.m. – The premier issues a statement: The province and the premier “are on the file”

At 12:28 p.m., a statement released by the premier stated:

I want to thank our emergency crews in Elliot Lake as well as those that have come from southern Ontario to help with the rescue effort for their good work around the clock.

I spoke to Mayor Rick Hamilton this morning. As we anxiously wait to learn more about anyone thought to be missing in Elliot Lake, our thoughts and prayers are with their families, and also with those who have been injured and indeed with the entire community.

During a crisis like this, I am reminded of the strength and resilience of Northern Ontarians, and how by pulling together with our friends, families and neighbours, we can get through these difficult times.<sup>68</sup>

Mr. McGuinty testified that, generally, statements were released by his office whenever it was determined that there was a need to convey information to the public. In this case, his office knew that Ontarians would be concerned about one of their own communities and the crisis that was unfolding there. Usually, Premier McGuinty would review and approve the content of statements released to the public in his name. He would occasionally amend them, but in most cases, the need for, and preparation of, the statement was driven by his staff. They would know when a statement was required, so that by the time the premier thought about issuing a statement, a member of his staff had already started to work on one.<sup>69</sup>

In his testimony, Mr. McGuinty explained that this statement was issued to tell Ontarians that the province and the premier were “on the file,” and to provide reassurance and comfort. The statement referred to the fact that he had spoken to the mayor, so that Ontarians and the people of Elliot Lake would know they were in close communication.<sup>70</sup>

The staff in the Premier’s Office considered issuing a second statement from the premier at 4:00 p.m. However, when they did not receive an update from officials about any deaths or persons confirmed to be missing, they decided there were no new developments to react to in a release.<sup>71</sup> Indeed, the situation report (SITREP) that had been issued that day by the Provincial Emergency Operations Centre (PEOC), based on information current at noon, did not reveal any new information.<sup>72</sup>

### **3:25 p.m. – Minister Meilleur speaks to Michael Mantha: All resources from the Ministry of Community Safety will be made available**

At 3:25 p.m., Minister Meilleur contacted Mr. Mantha, who had been calling every ministry he thought could be of benefit to the community. Mr. Mantha understood that Ms. Meilleur was the minister responsible for municipal housing and that her ministry would be directly involved with the event. He testified that, during his conversation with Ms. Meilleur, she assured him that all the necessary resources from her ministry were going to be made available and that he could expect regular updates from her. She also informed him that her office staff (more particularly Mr. Chanzy) would be on hand for anything he required. Mr. Mantha was getting the ball rolling for the support he needed from the province.<sup>73</sup>

### **6:04 p.m. – Mr. O’Leary reiterates his request to the Ministry of Labour regarding information about the Mall**

At 6:04 p.m., Mr. O’Leary once again pressed the MOL staff for information on the history of inspections and violations at the Mall. He was advised by Mr. Killorn that they were in the process of getting this information and that the MOL’s role on the scene was only advisory at this stage. Mr. O’Leary responded:

Thx. Understand your role on site is secondary, and I’m getting what I need from emergency officials. Let’s get the history as soon as possible tmrw morning, and you should also pls check to confirm no letters, etc, have come in to your ministry complaining abt the workplace or safety.<sup>74</sup>

It is apparent that Mr. O’Leary was understandably concerned about the possibility that employees had complained about the state of the Mall before its collapse. He wanted to obtain as much information as possible about any such complaints in order to be able to respond to inquiries.

### **6:32 p.m. – Elliot Lake press release constitutes the first official notification to the Premier’s Office of a possible fatality**

At 6:32 p.m., Mr. O’Leary forwarded to his colleagues in the Premier’s Office, including Ms. Codd-Downey, the press release that had been issued by the City of Elliot Lake at 4:40 p.m., informing the public for the first time that there might be a victim. The press release stated: “Evidence has been uncovered that leads us to suspect that there may be a casualty. The area is still unstable and dangerous. It is estimated by emergency crews that there will be 10–12 hours of further stabilization ... required in the area before the rescue crew is able to go in.”<sup>75</sup> This statement was the first official notification the Premier’s Office received that there might potentially be a fatality. It had not previously been advised of this information.<sup>76</sup> Mr. McGuinty testified that Ms. Codd-Downey would very likely have conveyed this information to him: He too had not received any official indication before then that there might be a casualty.<sup>77</sup> He explained that there had been musings and speculations in the media, but this press release appeared to be more concrete information. Although it was official information, it did not confirm any deaths.<sup>78</sup>

At 6:36 p.m., Mr. O’Leary sent an email to Mr. LeBlanc in which he gave his reaction to the City of Elliot Lake press release:

Seirge, is this really the most current info? Its [sic] coming to us an hour after the press release says a presser will be held, and media are already reporting, including running audio and TV, of what was discussed. So is this the most up to date info, what happened at the presser, when is the next update expected to us (and I would like one tmrw first thing, by 630–7am at the latest), and when is the next media update going to happen?<sup>79</sup>

At 7:22 p.m., Mr. LeBlanc responded:

I understand you are in contact with Debbie from Cab as well who is very familiar MCSCS.

I'm clearly not holding any information back.

I've pushed my ministry folk this weekend as well to ensure we have the most updated info.

Always working to get you the best information as fast as possible, I really don't see there to be any other option – you need to know when I know.<sup>80</sup>

It became apparent early on that local information on the status of the collapse and the response was flowing first to the media, via informal channels. Before official statements were issued by the local response team, this information was, unfortunately, being reported by the media.

### **Evening – The premier speaks to Mr. Mantha and provides him with assurances and a point person for future inquiries**

During the early evening of June 24, Premier McGuinty spoke with Mr. Mantha, who had some specific concerns about the consequences of the collapse, rather than the rescue effort itself. He wanted to be able to speak to someone in a position of authority on the political side in order to cut through the red tape and come up with solutions to a few practical challenges. Included among them was the need to ensure that government services which had been delivered out of the Mall would continue to be provided.<sup>81</sup>

Subsequently, at 7:19 p.m., Ms. Miller sent an email to several individuals, including Mr. O'Leary and Ms. Codd-Downey, in which she stated:

Jason / John –

P spoke with Mantha. Two follow-up items:

(1) Mantha is very interested in relocating some government service offices (federal and provincial) which are no longer accessible because of the damage. P believes he will call upon our govt to get involved in this with funding. He says he already has alternate space picked out – some previously abandoned space located nearby.

And (2) he mentioned he would like somebody's phone number so he can contact them directly ... he already has some "liaison's" phone number but he is unsatisfied with this. P said he should stay in contact with Madeleine Meilleur and that P would look into the phone number issue for him. Can we give him a number closer to our government? Is it Madeleine's office he should be connecting with?<sup>82</sup>

Ms. Miller later emailed Mr. O'Leary and clarified that she did not want to provide Mr. Mantha with multiple points of contact. Rather, she wanted one person to be identified who would be responsive to his concerns.<sup>83</sup>

Mr. Mantha was ultimately told that he should deal with Mr. Chanzy, the chief of staff to Minister Meilleur. Her Ministry of Community Safety was not responsible for addressing the issues of the continuation of government services referred to by Mr. Mantha, but Premier McGuinty saw this solution as a cross-ministry approach to these types of challenges. Normally, someone as senior as the minister's chief of staff would not be appointed to look after such issues, but the premier thought it ought to happen in this case. In his view, Mr. Mantha was being very thoughtful in the approach he was bringing, and it was important that he be able to get a quick response to his concerns.<sup>84</sup>

Mr. Mantha testified that he spoke to the premier about securing the funding to move government services that had been in the Mall to an available building, the White Mountain Academy, at 99 Spine Road. Because the collapse had occurred at the end of the month, people were expecting services and assistance, including social



services cheques, by the beginning of the following week. The services in the Mall had included Algoma District Social Services, as well as employment and health care services.<sup>85</sup>

Mr. Mantha testified that he wanted to speak directly to Ms. Meilleur because he hoped to get things moving quickly. Eventually, he did get direct calls from Ms. Meilleur and established a good rapport with Mr. Chanzy. At this point, he was pleased with the results of his requests.<sup>86</sup>

### **7:45 p.m. – Telephone call between Mr. Hefkey and Mr. O’Leary: Live victims can survive several days if they have water**

On June 24, at 7:45 p.m., a teleconference took place between members of the Cabinet Office, the Premier’s Office, and Dan Hefkey, the commissioner for community safety, in order for Mr. Hefkey to provide the most up-to-date information about the situation.<sup>87</sup>

The teleconference had been organized at Mr. O’Leary’s behest. He testified that he had told Mr. LeBlanc and Ms. Conrad that various pieces of information were being supplied from different sources, and he was interested in having the most up-to-date and current information. Ms. Conrad had suggested a teleconference with Mr. Hefkey.<sup>88</sup>

The following notes appear in Mr. O’Leary’s notebook about this teleconference:

*Call w/ Dan Hefkey*

Updates – times of events – Continuity of Operations

Press releases – who to contact for Meilleur

Members of OPP Urban Rescue Team + 37 Toronto HUSAR team on the ground

- Step 1 = make scene safe, plan to move debris

- Make it safe for workers or anyone alive in the rubble

- Rotating shifts to go 24/7

◦ Dogs work for an hour then rest

- 12/24hrs – will continue to do so

◦ Rescue operation

Lead on ground = Elliot Lake emergency folks, we are there to support it

- Great relations w/ them

- Don’t want to compromise what folks are doing

Do not release figures: must be confirmed, local government to determine

- 1 death

- Likely there are others

- Was tapping, know where it was

- Estimate 3 people trapped

- Once HUSAS [sic] has confirmed all fine, will turn into recovery

- Coroner ready when needed

- Reluctant to share numbers – ratchets up speculation and anxiety

- A segment of the structure

- Don’t know if close together

- Can last several days, esp. w/access to water – 3–5 days ...<sup>89</sup>

Ms. Conrad, Mr. LeBlanc, Mr. Chanzy, Mr. O'Leary, and Mr. Hefkey participated in the teleconference. Mr. Hefkey explained that UCRT's and HUSAR/TF3's first task at the scene was to move debris to make the area safe for workers. He also noted that the teams would be operating on rotating 12-hour shifts over a 24-hour period and that the canine units would be working for an hour, followed by a rest. The response was characterized by Mr. Hefkey as a rescue operation, which Mr. O'Leary understood meant that the objective was to rescue anyone who might be alive within the debris of the Mall.<sup>90</sup>

Mr. Hefkey further explained that the Elliot Lake emergency responders were in charge and leading the effort. Any provincial assets that were deployed, such as UCRT, would be supporting the local authorities. He said that the relations between the Elliot Lake emergency response team and the provincial assets were great and that it was important not to compromise anything the local authorities were doing. He explained that it was for the local government to determine what, when, and how information would be released about victims or injuries, but he did not say why. He also informed the participants on the call that there was one confirmed death and that there were likely others.<sup>91</sup> He explained that the responders had heard tapping, and they knew where it was coming from. They estimated that three people were trapped in the debris. Mr. Hefkey advised that once HUSAR/TF3 determined that all the victims who were alive had been rescued, the operation would turn into a recovery. He further indicated that the Coroner's Office was on stand by and ready if needed. He reaffirmed the reluctance of the responders and the authorities in Elliot Lake to share numbers because it would increase speculation and provoke anxiety.<sup>92</sup>

The three notations by Mr. O'Leary starting at "A segment of the structure" reflect answers to questions that were put to Mr. Hefkey by Mr. O'Leary and others on the call:

- When asked what exactly collapsed, Mr. Hefkey indicated that a segment of the structure had collapsed.
- When asked whether it was known where the victims were located, he said that they did not know whether the victims were close together or not.
- When asked if there were live victims in the debris and how long they could survive, Mr. Hefkey indicated that they could survive several days, particularly if they had access to water. His estimate was three to five days. Mr. Hefkey did not give any source for that information.<sup>93</sup>

Mr. Hefkey testified that he did not specifically recall the conversation. He agreed that Mr. O'Leary's notes generally reflected what he would have told him. He clarified the following points:

- He would have received the information with respect to the rotating shifts from the fire marshal or the Provincial Emergency Operations Centre. At that point, Mr. Hefkey had not spoken to any of the members of the HUSAR/TF3 or UCRT teams.
- He understood that the rescue team was looking for somebody who was alive.
- The Elliot Lake emergency responders were the lead on the ground. He may or may not have advised Mr. O'Leary that Chief Paul Officer, the Elliot Lake fire chief, was the incident commander, that the rescue team had its Community Control Group up and running, and that the province's role was to support the rescue team, not just with HUSAR/TF3 and UCRT but also with other assets (such as having Robert Thorpe, a fire protection adviser from the Office of the Fire Marshal, working with Chief Officer). In Mr. Hefkey's view, the Elliot Lake emergency team was in charge.
- With respect to Mr. O'Leary's note about the survival time of victims, Mr. Hefkey testified that he informed Mr. O'Leary that, "based on what we knew about humans," a healthy human being can last between three and five days without water. If there was a water source, the person trapped could live for a longer period of time.<sup>94</sup>

Later that evening, at 8:35 p.m., Mr. LeBlanc sent an email to Mr. O'Leary in which he confirmed that information gathering was critical. Mr. O'Leary replied:

No worries, you guys are on top of stuff. But getting into a situation where media is saying one thing, and our updates say another, that's something we need to clear up. Lots of media and lots of rescuers leads to lots of news, but lots of confusion over the actual state of affairs. Glad we got that cleared up ...<sup>95</sup>

Mr. O'Leary testified he was concerned that the information being reported through government channels as well as through other sources such as the media continued to be unconfirmed and unaligned.<sup>96</sup> The next morning, June 25, Mr. O'Leary emailed Ms. Conrad, thanking her for setting up the conference call, and writing:

Didn't respond last night, I hit save not send! But that was very valuable I think: it's frustrating when media says one thing and our own folks say another, just raises question is it bad info to the media, or is it our folks not telling us. Really helpful to hear the facts. Thanks a lot for setting it up and on such short notice.<sup>97</sup>

**"But getting into a situation where media is saying one thing, and our updates say another, that's something we need to clear up. Lots of media and lots of rescuers leads to lots of news, but lots of confusion over the actual state of affairs."**

**– John O'Leary**

Mr. O'Leary testified that he was concerned that many pieces of information were being provided by various sources and that it had been helpful to have Mr. Hefkey provide a full and complete picture with the level of detail that he did. He expected that whatever information there was about the situation (whether confirmed or suspected) would be shared with him and the Premier's Office.<sup>98</sup>

Mr. McGuinty testified that he would have expected Mr. O'Leary to share information that arose out of the conference call with him. That information included the fact that there was one confirmed death and that the rescuers had heard sounds of tapping, which would indicate that someone was still alive. Mr. McGuinty was not sure whether he learned these points on the evening of June 24 or the following day, but he would be surprised if he did not receive the information quickly. Any such information came to him with the proviso that it could not be shared. If it was standard protocol that it was the municipality's responsibility to make the information public, he would have respected it.<sup>99</sup>

At 8:32 p.m. on June 24, the Provincial Emergency Operations Centre circulated another situation report. It contained the official government information as of 8:00 p.m. and was not up to date. The new information read:

- The area is still unstable and dangerous. As of 2012-06-24, the estimation by on-site emergency crews is that there will be approximately 10–12 hours of further stabilization effort required before a rescue crew will be able to go in.
- Examination of the scene continues to indicate that this is still a rescue. Evidence has been uncovered that suggests there may be a casualty...
- An information centre for the public has been established at W.H. Collins Hall.<sup>100</sup>

In fact, as I set out earlier, the beam overhanging the rubble pile was cut and removed in an operation that took approximately a half hour and started at about 7:50 p.m., according to the notes and testimony of the URCT's Sgt. Jamie Gillespie.<sup>101</sup> After the beam was removed, four riggers were lowered onto the pile and, at 11:10 p.m., began removing the fallen car and the concrete slabs.<sup>102</sup>



## June 25 – From the news of a live person, to the stopping of the rescue, to the intervention of the premier, to the resumption of the rescue / recovery

### Mr. Chanzy becomes Mr. Mantha's contact person

On June 25, at 8:46 a.m., Mr. O'Leary sent an email to Mr. LeBlanc and Mr. Chanzy in which he said that it made more sense for Mr. Mantha to have only one contact person, one who was senior enough to understand and handle Mr. Mantha's needs appropriately. Mr. O'Leary thought that the Ministry of Community Safety would be in the best position to know what could be confirmed (or not) to Mr. Mantha and to put him in touch with emergency officials.<sup>103</sup> Mr. Chanzy agreed to take on this role.<sup>104</sup>

The staff in the Premier's Office were still under the impression that all government services continued to be available in Elliot Lake after the collapse.<sup>105</sup> Mr. Chanzy, however, reported to Mr. O'Leary that Mr. Mantha had told him that some provincial government offices were located in the Mall, and that he was concerned about the continuing delivery of their services. Mr. Chanzy also advised that Mr. Mantha inquired about special funding to compensate businesses that were located in the Mall and to assist with relocation.<sup>106</sup> Mr. Mantha testified that the Algoma District Social Services, Service Canada, and health care services were located in the Mall.<sup>107</sup>

Mr. O'Leary passed Mr. Mantha's concerns on to the Cabinet Office. He asked that all ministries be canvassed to confirm whether they or their partners had been affected by the collapse.<sup>108</sup>

### Mr. Mantha understands that he cannot assist with rescue but tries to help with the economic impact of the collapse

On the morning of June 25, Mr. Mantha met with business leaders in Elliot Lake to determine the overall

impact of the collapse (aside from the governmental ministries and services) and what could be done to remedy the situation as quickly as possible. He testified that some 200 to 300 people were going to be affected directly or indirectly with loss of income, loss of employment, the stress of having lost a job, as well as the stress of dealing with the entire tragedy. Mr. Mantha wanted to get a sense of the economic impact of the collapse on the community. City councillors as well as the Chamber of Commerce were involved in the meeting. Mr. Mantha realized there was nothing he could do at the time with the rescue efforts, though he could look into other issues. He offered himself and his staff as resources to provide any assistance, including facilitating responses from the Government of Ontario.<sup>109</sup>

On the morning of June 25, Mr. Mantha met with business leaders in Elliot Lake to find out the overall impact of the collapse (aside from the governmental ministries and services) and what could be done to remedy the situation as quickly as possible.

### Mr. Mantha's reaction to communication issues: He would need to get information from the street

Mr. Mantha was never invited to attend the Community Control Group (CCG) meetings. He explained that, initially, the meetings included a group of councillors together with the individuals involved in the rescue. As a result, too many people were attending who did not have a formal role in the rescue. The group then decided that only individuals listed in the emergency plan should attend the meetings on a regular basis. The councillors who were excluded as well as Mr. Mantha would be invited by the mayor or the chief administrative officer for a briefing after the meetings.<sup>110</sup>

In his testimony, Mr. Mantha said that, initially, information was being relayed to the public by regular briefings at the civic centre. Mr. Mantha and the councillors would also share the information with the public as soon as it was given to them ("We would bring it out as quickly as we could on the street"): in his view, the more information that was known, the better. It seemed as though the rescue efforts were progressing very slowly, and a level of frustration was starting to mount in the community.<sup>111</sup>

Mr. Mantha clarified that although he was never told that the purpose of the CCG briefing meetings was to provide him and city councillors with information to be passed on to the public, he assumed that was so because the information provided to them was the same as was given at the press conferences. Sometimes, however, by the time they got the information in the briefing, it had already been released to the public. In some instances, they had to go out to the streets to get the information. There were never any discussions during the briefings about the way information would be provided to the public.<sup>112</sup>

### **12:18 p.m. – The Premier's Office learns that there has been one death and that one person is thought to be alive in the rubble**

At 12:18 p.m., Mr. O'Leary sent an email to his colleagues at the Premier's Office, including Ms. Codd-Downey, entitled "Elliot Lake: News Conference Summary – confirmed 1 person trapped, alive as of 4am." There he summarized what he had learned from watching the noon press conference:<sup>113</sup>

... Still a rescue operation, police confirm at least 1 person is alive and trapped.  
 Toronto Police HUSAR  
 Working through the night  
 Removed damaged ibeam that collapsed, turned over to MOL for investigation  
 Made use of large cranes to help remove large concrete debris on scene  
 Around 4 am this morning, OPP used a piece of equipment to determine signs of life previously spotted  
 Diligently working to reach that person  
 Setback: structure is still shifting and unstable  
 Escalator inside is shifting, had to pull crews back to reassess entry point  
 Have not stopped working, are working on other entry points to keep moving towards the person  
 Will not be able to use cranes, the area is now a no-go situation  
 Using equipment to assess situation, but is unsafe, and we have to be very careful  
 Moving forward with rescue, but cant [sic] give a time frame ...  
 Any fatalities?  
 One fatality confirmed. No identification, a sighting of an arm or leg, have not gone near victim, focus is on rescue.<sup>114</sup>

Mr. O'Leary testified that, to his knowledge, this press conference was the first public confirmation that there had been a fatality.<sup>115</sup> Mr. O'Leary also received summaries of the press conference from others, including Mr. LeBlanc,<sup>116</sup> Greg Flood (a MCSCS staff person),<sup>117</sup> and Robert Di Giovanni (an issues management team member in the Cabinet's Office).<sup>118</sup> What was happening in Elliot Lake continued to be of great interest to those in the Premier's Office.<sup>119</sup>

Mr. McGuinty testified that while he was informed about the developments, he was not made aware of all the specifics in Mr. O'Leary's summary, such as the fact that the beam had been removed. He stated that the press conference was the first public confirmation that there had been a death and that, as of 4:00 a.m. that morning, somebody was alive and trapped in the rubble pile. He learned these facts from his staff – and knowing this information changed things for him from both a practical and an emotional perspective. On a practical level, his office staff needed to put out a press release to express their sympathies to the families, to recommit themselves to the community, and to encourage the rescue workers. On the emotional level, he became more invested in the crisis. Once he was told that somebody could still be alive, he wanted to help.<sup>120</sup>

As Mr. McGuinty explained, this event quickly became all-consuming for his staff. A very compelling story was unfolding, one person had died, and a lot of tasks needed to be done. He and his staff were committed to do whatever they could to help.<sup>121</sup>

### **1:05 p.m. – The Premier's Office issues a second press release: The premier expresses his sympathies to victim's family**

At 1:05 p.m., the Premier's Office released another statement:

Today Premier Dalton McGuinty released the following statement, after confirmation that one person has died in the collapse of a mall roof in Elliot Lake:

"Today, I want join [sic] with people across Ontario to express our deepest sympathy to the family who have lost a loved one in this terrible tragedy.

To those people of Elliot Lake: thank you for pulling together in these difficult days and for taking care of friends and neighbours.

And to the first responders from in and around Elliot Lake: thank you for your tireless efforts since Saturday. And on behalf of all Ontarians, I also want to thank those emergency services workers who came from across our province to assist in the rescue and recovery efforts.

When one community in Ontario hurts, it touches us all, and we will continue to stand together to see our fellow Ontarians through this tragedy."<sup>122</sup>

Mr. McGuinty testified that he had likely been made aware of the confirmed death before it was made public in Elliot Lake. It appears that the premier's staff had been working on a second draft of the press release at 12:37 p.m.<sup>123</sup>

### **11:34 a.m. and 2:40 p.m. – Mr. O'Leary receives information from the Ministry of Labour and the Cabinet Office**

At 11:34 a.m., in response to his request of the previous day for the history of the inspections at the Mall, Mr. O'Leary was provided with a list of interactions going back to 2009 which the MOL had had with the Mall.<sup>124</sup> Mr. O'Leary questioned the exhaustiveness of the list he was given.<sup>125</sup>

At 2:40 p.m., following his queries of earlier that day resulting from Mr. Mantha's information, Mr. O'Leary received an email from the Cabinet Office. It outlined the information it had received from various ministries on the provincial services that had been affected by the collapse.<sup>126</sup>

### **2:50 p.m. – The Premier's Office is advised that the rescue has been called off**

At approximately 2:50 p.m., Mr. O'Leary received a call from Ms. Conrad. She told him that a decision had been made to call off the rescue operations and to move into a recovery phase. She said that the remainder of the building would then be demolished.<sup>127</sup>



During his conversation with Ms. Conrad, Mr. O'Leary took the following notes:

*From Hefkey:*

- Closing down the site, load around escalator
- No first responders
- Too dangerous to work
- Trying to contact Mayor now<sup>128</sup>

Ms. Conrad explained to Mr. O'Leary that the load on the escalator and its condition made it too dangerous for the first responders to continue working.<sup>129</sup> Mr. O'Leary testified that he was disappointed with the development and knew it was a very difficult decision. On receiving this information, he immediately requested a briefing with Mr. Hefkey.<sup>130</sup>

At 2:53 p.m., Mr. O'Leary sent an email to Mr. Livingston, Ms. Miller, and Ms. McCann, entitled "URGENT: Elliot Lake," in which he wrote:

Bad news from emergency officials. The structure and debris is too unstable for work to continue. Emergency responders are about to be pulled back, and work will halt on the site. The mission will turn from rescue to recovery: that means attempts to retrieve anyone trapped in the debris, including at least one person confirmed to be alive as of this morning, is stopping. Emergency officials are trying to track down the Mayor now. I've asked our officials to brief me via conference call as soon as they are able. Once crews pull back and work stops, it'll become evident to the public at the scene that the rescue operation has been abandoned. They are going to have to communicate this, but I'm not clear yet how they plan to do so, will get that picture on the conference call.

I will circulate the info when I have it. Likely to happen very shortly.<sup>131</sup>

### **3:20 p.m. – First conference call between Mr. Hefkey and Mr. O'Leary: The rescue had been stopped despite three to five victims still in the rubble**

At approximately 3:20 p.m.,<sup>132</sup> Mr. O'Leary took part in a conference call with Mr. Hefkey, Ms. Conrad, and communications officials within the MCSCS.<sup>133</sup> Referring to his notes, Mr. O'Leary testified that Mr. Hefkey explained that there was, among the rescue workers, an emotional sense of failure and disappointment that they had let the people down. He said there had been so much hope earlier in the day from signs such as the tapping. He advised that the mayor, the Fire Department, and HUSAR/TF3 would now be in the best position to communicate the news, but he was unclear as to when it would take place. Mr. O'Leary testified that he asked what the next steps would be, now that the rescue was no longer continuing. Mr. Hefkey explained that, at this point, the steps would involve ensuring the safety of those on the rubble pile. Heavy equipment would be used at the site, and the work in question would be less focused on preserving the integrity of the victims' bodies within the debris. An outside observer would still see people working on the pile, and there would not be a perceptible change in status. Mr. Hefkey did not indicate where the heavy equipment would come from.<sup>134</sup>

Mr. Hefkey told Mr. O'Leary that it was believed there were between three and five victims still in the rubble. Mr. O'Leary did not remember whether he asked about the likelihood of anyone in the rubble still being alive and whether Mr. Hefkey mentioned anything in that regard. Mr. Hefkey indicated that local bereavement counsellors would be available for the emergency workers and for members of the public. The next step, after the bodies were identified and notification given to next of kin, would be for the Office of the Fire Marshal to investigate.<sup>135</sup>

At 3:27 p.m., while still on the conference call with Mr. Hefkey, Mr. O'Leary sent an email to Ms. Miller and Ms. McCann: "We need to huddle on Elliot Lake ASAP please. This is urgent and is [going] to require a statement

I believe from the Premier.” Ms. Miller asked whether they could meet now.<sup>136</sup> When Mr. O’Leary finished speaking with Mr. Hefkey, he joined Ms. Miller and Ms. McCann.<sup>137</sup> He told them what he had learned from Mr. Hefkey. They all reacted professionally but were disappointed at these difficult decisions. They had a number of additional questions.<sup>138</sup> They also discussed whether the premier should be making a statement following the 5:00 p.m. local press conference, when they understood an announcement would be made that the rescue efforts were not going to proceed.<sup>139</sup> They decided to prepare a statement from the premier to react to the situation, although they had not been authorized to issue such a statement.<sup>140</sup>

#### **4:40 p.m. – Second conference call between Mr. Hefkey and Mr. O’Leary: Emotions are high; MOL had told the rescue team that the situation is too unstable for a rescue**

Mr. O’Leary spoke to Mr. Hefkey again at 4:40 p.m. Before doing so, he told Mr. Livingston that the rescue had turned into a recovery. He also discussed with him the potential response from the premier.<sup>141</sup> He emailed Ms. Miller and Ms. McCann about that discussion, writing: “Only comment he [Mr. Livingston] made was, is it right for the P to issue a stmt today or should it be the Minister? I still think its the P on this, if you guys feel otherwise, he says he’ll back up our call.” Ms. McCann advised that, because there had been fatalities, the premier should issue the statement.<sup>142</sup>

Ms. Conrad joined Mr. O’Leary on the 4:40 p.m. call with Mr. Hefkey, who told them that emotions were running high. He said that the MOL engineer had explained to Staff Insp. William Neadles, the HUSAR/TF3 commander, that the situation was too unstable for a rescue operation to continue. A recommendation had then been made. At that point, Staff Insp. Neadles decided to suspend / discontinue the operation. The first responders and the rescuers were unable to confirm if anyone was deceased in the debris, but they would not be able to continue the rescue without killing that person. They were advised that, in terms of next steps, the scene would be turned over to the control of the Elliot Lake fire chief. They were also told that the HUSAR/TF3 leader was the incident commander: he was in charge of and responsible for the rescue operations and the rescue itself.<sup>143</sup>

In his notes of the teleconference, Mr. O’Leary wrote:

Yes they will – have a united front

They want to prolong it, want to attempt a rescue<sup>144</sup>

Mr. O’Leary explained that he asked Mr. Hefkey whether the decision that would be announced would be a united one by all the individuals involved in the rescue. Mr. Hefkey informed him that HUSAR/TF3 would be leaving the community and returning to Toronto, but that the UCRT team wanted to prolong its stay and attempt a rescue. The news regarding the rescue being called off would indeed be made with a united front.<sup>145</sup>

#### **5:00 p.m. – The premier’s staff learns more from the local press conference**

Mr. O’Leary watched the 5:00 p.m. press conference and sent a summary of it to his colleagues in the Premier’s Office at 5:29 p.m.<sup>146</sup> He relayed to them the information that Staff Insp. Neadles had provided at the press conference; they had tried several avenues of rescue, but all of them had been unsuccessful. The MOL and HUSAR/TF3 engineers had inspected the building and determined it could collapse at any moment. He had made the decision not to put the workers back on the pile, and the facility was now turned over to the authorities. The MOL would issue an order for the owner to hire an engineer to demolish the building, though there were still people in the Mall in an unknown condition. Ms. McCann replied to his email: “What I heard was that the guy who was alive at noon might still be alive but they’re going to tear down the building anyway.”<sup>147</sup>

By 5:06 p.m., the Cabinet Office had prepared a draft press release on behalf of the premier. It stated:

Like all Ontarians, I was saddened to learn that efforts in Elliot Lake have moved from rescue to recovery.

This news comes as a terrible blow to the people of Elliot Lake, and especially to those who have yet to learn of friends and family still missing. Our thoughts and prayers go out to them and we will continue to stand by as we await final word on the victims.

Our hearts are also with the dozens of emergency workers from Elliot Lake and beyond who rushed to the scene this weekend. They put their own lives at risk to save people they never knew. Along the way, they reminded us of the sacrifices our first responders make every day.

Ontario is a large province that feels much smaller at a time like this, and I know all Ontarians will come together to support the people of Elliot Lake as they recover from this tragedy.<sup>148</sup>

Between 5:30 p.m. and 6:31 p.m., a series of emails were exchanged at the Premier's Office and the Cabinet Office about a possible statement by the premier following the press conference. At 6:30 p.m., the decision was made that the draft statement would not be issued. Mr. O'Leary could not explain why this decision was made. He did not believe that the premier ever saw this draft.<sup>149</sup>

### **5:51 p.m. – Mr. O'Leary urges the MOL to outline its role and the actions it would take in the recovery**

At 5:51 p.m., Ms. McCann sent an email to Mr. O'Leary and other colleagues at the Premier's Office referring to a CBC story. She stated: "This is from CBC ... pegging the destroying of the building on the MOL."<sup>150</sup> Mr. O'Leary understood from Staff Insp. Neadles's comments, during the press conference, that the site would be turned over to the fire chief and that the MOL would subsequently issue orders resulting in the demolition of the Mall.<sup>151</sup>

At 5:51 p.m., Mr. O'Leary sent an email to Mr. Kaderdina, Mr. Killorn, and Mr. Chanzy urging Mr. Kaderdina to have his deputy minister's office in the Ministry of Labour speak with its equivalent in the Ministry of Community Safety and Correctional Services to coordinate the next steps. Mr. O'Leary concluded by saying: "This is very urgent pls."<sup>152</sup> He expressed this urgency because he anticipated that the news regarding the MOL issuing various orders as the recovery phase began would lead to subsequent media inquiries about the ministry's involvement. He wanted these two offices to work together so that everyone could understand precisely the role and the steps that the MOL would be undertaking.<sup>153</sup>

Mr. Chanzy replied that he would need to know the next steps before contacting Mr. Mantha. Mr. Kaderdina responded that no orders had been issued yet by the MOL, and he was not sure where the CBC was getting its information.<sup>154</sup>

At 6:34 p.m., Mr. O'Leary replied:

So this is what we need MOL to clarify asap in terms of what next steps are going to be. No order has been issued, yet. Will you be issuing an order? Is that the process now? What is the process? Have you taken over the scene, has your investigation begun etc. How are we going to be sharing info w the public abt what role, a stmt in the morning?

The emergency responders told the media that the decision to suspend the rescue, even with the chance that someone was alive buried in the rubble, was made based on mol advice, and that next steps involve mol taking over an investigation, issuing an order to the owner to hire a firm and submit a plan to mol for approval to clean up the site, including removing debris and demolishing any part of the building that may need to be demolished.

Fahim, can we jump on a quick call w you to discuss further asap?<sup>155</sup>



Mr. O'Leary testified that, in his understanding, the MOL was providing assistance to emergency responders on an as-needed basis during the rescue phase of the operation, whereas it would now be taking a more active role in terms of various orders that would be issued.<sup>156</sup> He was trying to determine what steps were being taken by the MOL. He spoke with Mr. Kaderdina and reiterated to him the information he needed. Mr. Kaderdina repeated that officials in the ministry had informed him that no orders had been issued.<sup>157</sup>

### **6:00 p.m. – The premier becomes aware that the rescue has stopped: He is shocked and finds it unacceptable**

Mr. McGuinty testified that because he had been on an extended phone call, he first became aware around 6:00 p.m. that the rescue had been called off. Ms. Sobers gave him the news, saying it was unsafe for the rescue workers to continue the search. Nothing had been conveyed to him in terms of other options being considered. She told him that the decision was “absolute. It was over.” Mr. McGuinty testified that he was shocked. In his view, the decision was “unacceptable.” He recognized he was not an expert in these matters but asked himself whether there were other ways to get to an individual who is trapped inside a structure. He immediately began to think, “Well, if we can't get at them from the inside, is there a way to begin to dismantle the building from the outside?” Given that a living human being could very well be under the rubble, “to do nothing would be for death to ensue.” He testified: “So to me, we had to try to do something.”<sup>158</sup>

The premier then spoke to Ms. Miller. “What the heck is happening here?” he said – or words to that effect. “How can this be possible? Why have they stopped the search? I think we are going to need to find a way to do something about this, or find a way to do something.” He asked for a conference call with his staff, and then with the people on the ground in Elliot Lake, so that he could get a better understanding from them and canvass alternative plans.<sup>159</sup>

Mr. McGuinty confirmed that the draft press release reacting to the news of the rescue's cancellation was never shown to him. Nevertheless, he characterized the draft as a rational, responsible approach to the information that had been received. His staff had just received terrible news that came from experts. According to Mr. McGuinty, they could not question it; the rescue attempt was over. This statement represented the staff's thinking at the time – and it was a standard response to news of that sort. It did not, however, represent his own thinking. Nobody ever discussed with him a statement along these lines. Mr. McGuinty's attention was first drawn to this document when he received it in preparation for his testimony.<sup>160</sup>

### **The premier: “If there is still a chance they are alive, we owe it to them to try”**

#### **The premier's staff questions whether anything else can be done**

At 6:36 p.m., the Provincial Emergency Operations Centre circulated a situation report that contained information current as of 4:00 p.m. The new information read:

- One person is confirmed to have died in the collapse. This person has not yet been identified.
- As of 1500hrs, 2012-06-25 operators with the HUSAR team have determined that the mall structure is too unstable for responders to safely continue with rescue operations. As a result, rescue operations will immediately transition to recovery and demolition operations.
- The PEOC has deployed an EMO Field Officer to Elliot Lake to provide advice, assistance and liaison to the community.
- The Ontario Commissioner of (sic) Community Safety, Dan Hefkey, is expected to visit Elliot Lake tomorrow, 2012-06-26.<sup>161</sup>

Mr. O'Leary confirmed that he received this report and that it was the official notification within the Ontario government of the decision to transition to recovery and demolition.<sup>162</sup>

At 6:47 p.m., Mr. O'Leary sent an email to Ms. Conrad, asking her to identify the commander on the scene at that point. He had been asked who was in charge now that the response had become a recovery rather than a rescue.<sup>163</sup> She replied that she would check, but that she believed it was the fire chief.<sup>164</sup>

At 6:57 p.m., Bradley Hammond, the associate press secretary at the Premier's Office, sent an email to several people, including Mr. O'Leary, in which he wrote:

CBC just phoned asking for comment – wants to know if the Premier thinks rescue is being called off too soon. She specifically referenced 9/11 and people being pulled from that well after the incident.

On Twitter I've had people reach out and ask if a mining rescue team could be deployed – that they're experts and could find people.

Any word on when we'll have a statement? I worry we're going to wear a decision made by experts.<sup>165</sup>

At 7:08 p.m., Ms. McCann replied, writing that no statement would be issued from the premier that night. However, the MOL was working on a statement that would outline the steps resulting from the decision and the next steps.<sup>166</sup>

At 7:11 p.m., Ms. Miller replied to Ms. McCann, Mr. O'Leary, and Mr. Livingston only and stated: "I am wondering about him saying tonight that he is asking HUSAR to stay on site and for more experts to get on site and determine if there is another way."

At 7:21 p.m., Mr. O'Leary suggested a call among the premier, Mr. Hefkey, and Staff Insp. Neadles to discuss possible options.<sup>167</sup> He testified that because provincial assets had been deployed to Elliot Lake and Staff Insp. Neadles was the person who had decided to move to a recovery, he thought it would be appropriate for the premier to speak to both of them and hear the facts first hand. When Mr. O'Leary was asked why, when a decision had already been made, his colleagues were suggesting that the premier ask HUSAR/TF3 to stay and to get more experts involved, he explained that, like the people of Elliot Lake, members of the Premier's Office reacted to the decision by asking whether anything else could be done.<sup>168</sup>

The following email exchange ensued in the Premier's Office:

[At 7:23 p.m., Ms. McCann wrote]: It would be good to have p [Premier] look engaged and even better for him to be giving faint hope, at least until the bad news sinks in.

[At 7:24 p.m., Ms. Miller wrote]: I didn't want to give false hope. But I also didn't want to give up hope.

[At 7:26 p.m., Ms. McCann wrote]: We had to be absolutely sure there was nothing more we could do.<sup>169</sup>

### **7:30 p.m. – Conference call between the premier and his staff: The premier wants explanations from Staff Insp. Neadles and Mr. Hefkey**

At 7:30 p.m., the premier, Mr. O'Leary, Ms. McCann, Mr. Livingston, and Ms. Sobers took part in a conference call.<sup>170</sup> Mr. O'Leary's notes of the meeting indicate:

Rick, Oraziotti – connect with them on next steps

- MOL does not have control of the scene
- Trying to get scene turned over
- If now, when invest happens, can be issued w/ complying

MOL – “best in the country”

- Who cleaned up 9/11
- What happens next?
- Do we owe it to ppl in the community to take another look @ it?
- Demonstration of respect
- No reason to doubt experts [*sic*], but need to bring in our side expertise<sup>171</sup>

Mr. O’Leary testified that the meeting opened with him providing a high-level overview of what they had learned to date and what the next steps were believed to be.<sup>172</sup> Someone asked a question as to whether MPPs Rick Bartolucci and David Oraziatti would be contacted. Mr. O’Leary could not remember who made the first three points.<sup>173</sup>

Both Mr. O’Leary and Mr. McGuinty testified that the other notes referred to questions raised by the premier. During the call, he said:

Have we got the best people in the country in there now? Who was involved in the cleanup in 9/11? Did we send in our people down there? Are they up in Elliot Lake today? Do we owe it to the people in the community to take another look at this, i.e., the decision to halt the search? I believe that it would be a demonstration of respect. There is no reason to doubt the experts, but I’m raising the question, do we need to bring outside expertise?<sup>174</sup>

Mr. McGuinty testified that he was looking for a way to continue the search which did not compromise the safety of the rescue workers. After hearing from his senior staff, he now wanted to hear from the people who were on the ground in Elliot Lake to better understand what was happening, the challenges they were confronting, why they called off the search, and to begin to canvass options. He wanted to see if there was not something else they could do. Ultimately, he wanted to put his proposal on the table that, if they could not get the people from the inside, perhaps they could try to get them from the outside.<sup>175</sup>

Mr. McGuinty was advised by his staff about the public reaction to the news that the rescue was off: people were upset, angry, and hurt. It was a bad scene. Mr. McGuinty testified that his own staff were frustrated, very disappointed, and felt that they “were going to leave a community and an individual high and dry.”<sup>176</sup>

The meeting concluded with the premier asking for a teleconference that evening with the emergency responders, including Mr. Hefkey and Staff Insp. Neadles.<sup>177</sup> Subsequently, at 8:04 p.m., Mr. O’Leary emailed Ms. Conrad and Mr. Hefkey to arrange for the call between the premier, Mr. Hefkey, and Staff Insp. Neadles:

I’d like to change the call at 830 pls, cancel what we have now and repurpose for a briefing for the Premier. Premier would like to get on a call w you Dan and with the HUSAR incident commander to receive a briefing on today’s developments and next steps. Would like to go fwd at 830 ...<sup>178</sup>

### **8:05 p.m. – Mr. Hefkey speaks to Staff Insp. Neadles and asks him to consider other resources**

At approximately 8:05 p.m., Mr. Hefkey spoke to Staff Insp. Neadles. Mr. Hefkey made notes of the call:

Spoke with Bill Neadles. There is a true hatred for the owner of the Mall due to the historically poor conditions of the mall structure.

There are fire code issues.

Bill had just spoken with MPP Mantha about how they can speed up the operation.

The town is willing to work at doing what they can to assist



The mayor will do what it will take to bring the situation to closure.

There is currently no hotel in town for them and the crowd is turning ugly.

The CCG have been looking at alternative plans for what looks to be a recovery.

Bill explained that there is a slab concrete that is being propped up by the escalator that is buckling under all the pressure. This is all under tremendous weight / pressure and is what is causing the I beam to bend.

I asked that he consider other resources that he may wish to get for him in support of the mission.

I asked that he be available for a call with the premier at around 2100hrs this evening.<sup>179</sup>

Mr. Hefkey testified that, during this conversation, Staff Insp. Neadles was sharing with him what he was feeling and what he was hearing from the community. Staff Insp. Neadles advised Mr. Hefkey that there was “a true hatred for the owner of the Mall due to the historically poor conditions of the mall structure.”<sup>180</sup> Staff Insp. Neadles testified that he had the opportunity to look at some of the tweets that had been posted on social media and concluded that the public was not happy with either the Mall owner or the rescue.<sup>181</sup> The public thought that the rescuers had quit, had packed up, and were going home, and the comments clearly showed displeasure at the decision.<sup>182</sup> Although he claimed that he and his team would be going back to find other possible options, Staff Insp. Neadles admitted that it was fair for a reasonable person listening to his comments during the press conference to conclude that the rescue team had quit. He insisted, however, that if members of the public had listened to the overall comments made by the entire group at the press conference, they would not have reached that conclusion.<sup>183</sup>

Staff Insp. Neadles also reported to Mr. Hefkey a conversation he had had with Mr. Mantha in the parking lot of the church across the street from city hall.<sup>184</sup> While speaking to Mr. Mantha, Staff Insp. Neadles could not see the people in the vicinity, but he could hear them being loud and boisterous.<sup>185</sup> When he finally saw them, he described them as being very upset. He even told Mr. Mantha to advise the HUSAR/TF3 members not to go into the street because he was afraid they would provoke a confrontation.<sup>186</sup> Staff Insp. Neadles and Mr. Mantha spoke about the decision to stop.<sup>187</sup> Mr. Mantha asked Staff Insp. Neadles about the HUSAR/TF3 program and its funding. Mr. Mantha told Staff Insp. Neadles that he would get a phone call but did not say from whom.<sup>188</sup>

Staff Insp. Neadles reported to Mr. Hefkey that the mayor and his senior staff were willing to do whatever they could to help.<sup>189</sup> He also told him, as Robert deBortoli, Elliot Lake’s chief administrative officer, had said at the press conference, that the Community Control Group was considering how to remove the deceased persons.<sup>190</sup>

Mr. Hefkey then advised Staff Insp. Neadles to consider other resources, such as mining type resources. In his testimony, he explained that this suggestion was given in the context of supporting the recovery of the deceased.<sup>191</sup> Staff Insp. Neadles confirmed that he did not mention Priestly Demolition to Mr. Hefkey at that point because he had not then spoken to Sgt. Phil Glavin, a Toronto Police sergeant with HUSAR/TF3, about this option.<sup>192</sup>

Finally, Mr. Hefkey asked Staff Insp. Neadles to be available for a call with the premier. Ms. Conrad had advised him that the premier wanted to speak to both of them.<sup>193</sup>

### 8:00 p.m. – Sgt. Glavin contacts Priestly Demolition for the first time

As I set out earlier, Sgt. Glavin unsuccessfully tried to contact Ryan Priestly, the president of Priestly Demolition Inc., after speaking with Staff Insp. Neadles. He then contacted his brother (who works for Mr. Priestly), told him he was trying to reach his boss, and spoke to him about the possibility of using the crane with the long-reach arm from Priestly for the rescue. At about 8:00 p.m., Sgt. Glavin spoke directly with Mr. Priestly.<sup>194</sup>

Sgt. Glavin testified that he advised Mr. Priestly of what they were doing in Elliot Lake and that the rescue had been stopped. He told him that they could not reach into the building because of the distance and, in addition, that the escalator was a concern. He informed him that he was looking for the long-reach arm crane to enable them to extend the arm over the site and go down through a hole to deal with the escalator and make it safe. They would then proceed to rescue the victim. He told him that although he did not have authority to spend any money, he was phoning him to see if he would entertain the possibility and whether it was feasible. Sgt. Glavin sent Mr. Priestly one or more photographs.\* He described the elevation and where the long-reach crane would be able to sit. He told him of the challenges (how high up, how far over and how far down they would have to reach) at the front of the Mall. Sgt. Glavin also considered having the OPP pick up Mr. Priestly from Aurora in its helicopter so he could see the scene, but Mr. Priestly eventually advised him that he understood the situation and that the proposed visit would not be necessary.<sup>195</sup>

Mr. Priestly testified that Sgt. Glavin told him of the urgency of the situation, which he understood because it was all over the news. He understood that victims were still missing in the rubble, and that the emergency was still a rescue mission. He stated: "You know, I think everybody is anticipating and hoping there's still light at the end of the tunnel, right? There are still people alive in there."<sup>196</sup>

Sgt. Glavin had several conversations with Mr. Priestly in which he provided him with information regarding the characteristics of the building and the measurements Mr. Priestly had requested (such as the approximate height of the building, the structural steel framing, the size of precast slabs, etc.). Within an hour of first being contacted, and after these numerous conversations, Mr. Priestly advised Sgt. Glavin that his machine could probably do what they needed it for. He indicated to Sgt. Glavin that they would have to come and get the machine.<sup>197</sup>

When he was making these calls to Mr. Priestly, Sgt. Glavin was in the command tent area on the upper-level parking. He believed that Staff Insp. Neadles may have been present for part of the time he was there, near the end of the discussions with Mr. Priestly. I describe further below that the approval for the use of the Priestly equipment was received at approximately 1:46 a.m. on June 26.<sup>198</sup>

## **The premier: "We have to try and save this person"**

### **8:30 p.m. – The premier tells Staff Insp. Neadles to consider a Plan B**

At approximately 8:30 p.m., a conference call took place among the premier, Staff Insp. Neadles, Mr. Hefkey, Mr. Livingston, Ms. Miller, Mr. Wallace (secretary of the Cabinet), Ian Davidson (deputy minister, MCSCS), Mr. O'Leary, Ms. Conrad, Steen Hume (executive assistant to the secretary of the Cabinet), Ted Wieclawek (fire marshal), and Allison Stuart (chief of EMO).<sup>199</sup> Mr. O'Leary testified that it was unusual for him to be on a call with the premier, his chief of staff, and the secretary to the Cabinet.<sup>200</sup> As Mr. McGuinty observed, they "had a lot of clout on the phone."<sup>201</sup> The premier, as the most senior person, ran the call.<sup>202</sup> Mr. O'Leary and Mr. Hefkey took notes of the meeting.<sup>203</sup>

Staff Insp. Neadles testified that the premier expressed concern that everything should be done for the families and the City of Elliot Lake.<sup>204</sup> The premier said that, until proven impossible, nothing should stand in the way of the responders to further the rescue operation. The discussion covered what had transpired and what could be done going forward.<sup>205</sup>

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\* Sergeant Glavin was unable to recover these pictures, which were located on a Blackberry that stopped working.

The premier asked Mr. Hefkey and Staff Insp. Neadles to explain the decision to call off the search.<sup>206</sup> They provided information that was consistent with what had been made public at the earlier press conference. Mr. O'Leary noted, from their explanation, the words "only viable alternative"; he was already familiar with the rest of the information they gave. While Mr. O'Leary could not recall who spoke those particular words, Staff Insp. Neadles testified that they reflected accurately the decision made earlier in the day to stop the search.<sup>207</sup>

The premier then asked whether someone was alive within the rubble.<sup>208</sup> Staff Insp. Neadles said there was a remote chance that was true. He explained that the OPP had used a piece of equipment that could penetrate concrete to determine if someone below was breathing.<sup>209</sup> He did not comment on the reliability of that machine. He explained that the device had detected a faint heartbeat and that tapping had also been heard during a call out by a rescuer at a different time.<sup>210</sup> He reported that search dogs were then sent into the debris and, although the hits had been distinctive the day before, they were less so that day. Staff Insp. Neadles testified that he meant there had been a hit by the dogs indicating that somebody was alive in the rubble, but that the scent was not as strong as in previous hits.<sup>211</sup> According to Mr. McGuinty and Mr. O'Leary, Staff Insp. Neadles explained that the rescuers did not have any solid information beyond that timeframe as to whether the victim was alive.<sup>212</sup>

Staff Insp. Neadles also indicated during the conference call that he had received medical advice that, once the three large pieces of concrete covering the victim were removed, she could die immediately from sudden shock.<sup>213</sup> Mr. O'Leary did not recall whether Staff Insp. Neadles indicated the likelihood of that happening.<sup>214</sup> Staff Insp. Neadles testified that it was Dr. Michael Feldman who gave him this information.<sup>215</sup> In contrast, as I discuss elsewhere in this Report, Dr. Feldman's evidence, which I have no reason to question, was that crush injury, or crush syndrome, was treatable and that paramedics were aware of such treatment.<sup>216</sup> Dr. Feldman also testified, contrary to what Staff Insp. Neadles told the premier, that although there are life-threatening complications to removing a heavy weight from a patient who had been crushed, the medical team was anticipating and preparing to treat such injuries.<sup>217</sup>

Mr. McGuinty testified that he was never presented with any conclusive evidence that the trapped person was no longer alive. He therefore proceeded on the assumption that somebody in there was still alive.<sup>218</sup>

The premier then asked whether there was any way they could go into the building.<sup>219</sup> Staff Insp. Neadles replied they could not.<sup>220</sup> He indicated that he had sought the advice of the MOL and HUSAR/TF3 engineers, Roger Jeffreys and James Cranford, respectively. He went on to explain to the premier that, when the roof collapsed, a large beam had been displaced and it was close to where the two identified victims were located. A large piece of concrete had fallen at this time, pressure had been applied down and out, stresses were more than 100 percent over the limit, and he was advised that the Mall could collapse at any moment. Staff Insp. Neadles testified that Capt. Tony Comella, a team coordinator on HUSAR/TF3 from Toronto Fire Department, was the person who had advised him that the building could collapse, and that Mr. Cranford and Mr. Jeffreys had agreed.<sup>221</sup> Staff Insp. Neadles went on to explain to the premier that, if the Mall did collapse, it would take down everything two and three floors below. He did not want to put any of the rescuers in that situation.<sup>222</sup>

Mr. McGuinty testified that his reaction to this answer was as follows:

I didn't say it, but would have thought we can't accept that. There has got to be a way. So the way I was thinking all along was if that is my daughter in that building or my mother or my fiancée, I want no stone left unturned. We will do everything we possibly can to connect with that individual.

So that ... was informing my thinking and inspiring my efforts, that notion. So I didn't say that right then and there. I think I did say it in other opportunities, but that is what I felt. We have to find a way.<sup>223</sup>



The premier then asked whether anyone else would be better to do the job.<sup>224</sup> Mr. Hefkey's notes record the following answer by Staff Insp. Neadles: "There are no other options and no other team would be capable of coming in and pull[ing] the victims from the rubble pile."<sup>225</sup>

Mr. McGuinty testified that he said they should be painfully honest with each other: If they did not have the best people on the ground conducting the rescue operation, they needed to get them. He was assured they did have the right people there – and they were doing everything they could.<sup>226</sup> According to Mr. O'Leary, Staff Insp. Neadles answered that people in the community believed that mine rescuers might be able to get the victims out, though he indicated that a mine is different from a building. He explained that a building cannot be simply torn down because that effort in itself could cause another collapse. Moreover, no one was better at rescue from a collapsed building than HUSAR/TF3.<sup>227</sup>

Staff Insp. Neadles first testified that what he meant by this comment was that no other search and rescue team, or any other team, miner or otherwise, could or should be allowed back in that building, based on its structural integrity at the time.<sup>228</sup> Later, however, he said that when he spoke of "no other team," he meant not only the non-trained search and rescue teams but fully trained teams. He believed that no other search and rescue team in the country was trained in the same way as HUSAR/TF3 or had access to more equipment: He admitted, however, as I indicate below, that he did not know what actual equipment and capabilities Ontario Mine Rescue had available.<sup>229</sup>

The premier then asked whether they could actively dismantle the building and, if so, whether the worst result would be that the building would come down.<sup>230</sup> According to Mr. McGuinty, the suggestion was well received and welcomed.<sup>231</sup> Mr. McGuinty and Mr. O'Leary testified that Staff Insp. Neadles answered as follows:

- they could dismantle it, if they had a proper demolition team;
- they had done so in the past to recover bodies;
- the process was "easy"; however, if victims were alive and something fell on them, they would die; and
- the mayor wanted to explore options in this regard and expressed hope that HUSAR/TF3 would be willing to stay on site.<sup>232</sup>

The premier testified that he could not remember whether the name Priestly was mentioned during the conversation.<sup>233</sup> Mr. O'Leary testified that the name Priestly was not mentioned: the only reference was to heavy equipment. His notes make no mention of Priestly.<sup>234</sup> As I discuss below, Mr. O'Leary testified that he first learned of Priestly Demolition later that evening in an email he received from Ms. Conrad.<sup>235</sup>

In contrast, Mr. Hefkey's notes, confirmed during his testimony, recorded the following points:

Bill mentioned Priestly Construction as an option given the experience he had with them during the Bloor Street collapse. HUSAR does not [*sic*] the kind of equipment needed to mount neither such an operation nor the expertise to operate the machinery.<sup>236</sup>

When asked what he told the premier with respect to the possibility of dismantling the building, Staff Insp. Neadles stated that he raised the name of Priestly and testified as follows:

Well, I didn't give a lot of actual detail because I only had had the preliminary discussions with Sgt. Glavin where he outlined in a very general way what he believed that the Priestly team could do for us as far as advancing with and dealing with that escalator.

I didn't even get into a lot of detail. What I did mention I believe was that ... we were working on a plan, but I didn't get into ... any of the specifics of it. And then what the Premier said was, I believe, you know, and I recall was good, go forward with your plan and when you have got it ready to go, reach out to Mr. Hefkey for approval.<sup>237</sup>

In fact, the team was a long way from such a plan.

In his testimony, Staff Insp. Neadles agreed that the Bloor Street operation (a natural gas explosion in an apartment building), referred in Mr. Hefkey's notes, was not a rescue but rather a recovery.<sup>238</sup> He testified that the previous experience he had with Priestly was limited to a recovery situation, but he claimed that he had then had the opportunity to observe the Priestly operation and the way they dismantled the building with precision.<sup>239</sup>

Mr. Livingston asked whether there was anything that the federal government or the Canadian military could contribute.<sup>240</sup> Mr. McGuinty testified that he sensed that Staff Insp. Neadles was trying his best. He said:

... if there is anything we can do, even if there is a low chance ... Then we have got to do it to try to save this person. As it stands now, the options will definitely result in death ... you are telling me there is a chance this individual is still alive and there is [a] chance that we could get at them by dismantling the building. We owe it to them, and we owe it to the community to try. I understand it is very risky, so you need to communicate that up front. You need to convey it to the community, "This is [a] tricky, delicate, risky procedure that we want to pursue. The place is like a house of cards. We pull down the wrong card, the whole darn thing may collapse. But it is the only choice that we have and we are not going to do nothing." So I thought it was really important to convey that to the community ...<sup>241</sup>

... I have now been told that there is some expertise; there is some heavy equipment that could be useful in these circumstances. I'm now saying that would be helpful. I think we owe this to the community with a life at stake. We owe it to them ...

... Whatever you need we'll help you get that.<sup>242</sup>

**"This is [a] tricky, delicate, risky procedure that we want to pursue. The place is like a house of cards. We pull down the wrong card, the whole darn thing may collapse. But it is the only choice that we have and we are not going to do nothing."**

**– Premier McGuinty**

Staff Insp. Neadles agreed that the premier was essentially saying to him that if the status quo was allowed to persist, no one would survive. He agreed that if they did nothing, there would be no rescue.<sup>243</sup>

When asked to explain further about the risk the premier was referring to, Staff Insp. Neadles testified:

- A. Well, as I think you have probably heard, if we just went in there and did the demolition as it was called, that would be risky that pieces would then further impact where the victims were lying.
- The plan from what we were working towards was to do it as precisely and as accurately as possible, and that is why we chose Priestly. With the piece of equipment that he had, with the expertise that we know they have, with the person we knew was operating the crane, I had a good sense of feeling that Mr. Priestly could come in and, as we laid out the plan to its final stages of what we did put together, he would be the best person with the best piece of equipment to enact as safe a demolition to that front corner as we possibly could without wrecking the rest of the building.
- Q. I think you are little ahead of us here, because at this phone call –
- A. I hadn't done that yet.
- Q. – you are a long way from a plan; correct?
- A. Yeah, well, not a long way, but we are not there.
- Q. Right. So am I safe in saying that the risk that is being talked about here is in the course of trying to take the building apart, it could result in their death?
- A. There is that risk. That is the risk.
- Q. Right, so it was being weighed against if you do nothing, they are going to die for sure, and there is a risk involved in taking the building down but it is better than the other option?
- A. Yes, sir.
- Q. That is really what it boiled down to?
- A. The risk versus the reward, yes.<sup>244</sup>

Staff Insp. Neadles also agreed that the premier made it clear to him, and he agreed it was important, that, once the plan was formulated, he needed to communicate to the public that the whole effort was a very risky operation.<sup>245</sup>

At this point in the conference call, Staff Insp. Neadles advised the premier that the families were willing to sign “a waiver that they would be prepared to do whatever it takes to restart the rescue, to rescue their loved ones.”<sup>246</sup>

Mr. Davidson asked whether the rescue teams had the necessary expertise. Staff Insp. Neadles replied that they did not, but that, with an operator and other material, the HUSAR/TF3 team would be able to proceed.<sup>247</sup> Mr. Davidson asked if Staff Insp. Neadles could get a list of what he needed, and the province would try to provide him with those resources. Staff Insp. Neadles stated that he would do what he could, to which the premier replied that it would be helpful if he provided the province with a list. The premier reiterated that “we owe it to the community, with a life at stake, we owe it to them[,] and Bill, we will let you do that.” Mr. Hefkey replied that they would provide anything they had to assist.<sup>248</sup>

The premier continued: “[T]ime is the enemy ... whatever needs to go, whatever we need to get, you know, we will go and get them.” He asked Staff Insp. Neadles, Mr. Hefkey, and Mr. Davidson to confirm that it was not possible to permit volunteers to assist.<sup>249</sup> Staff Insp. Neadles testified that this comment was a reference to the discussions about the possibility of having miners or other organizations enter the building. He was absolutely against that eventuality because these people did not have the expertise and the training that he believed were needed for a structural collapse. Staff Insp. Neadles admitted, however, that at this time he was not even aware of the organization Ontario Mine Rescue or the exact capabilities of mine rescuers. Staff Insp. Neadles claimed that in a discussion he had had about mining with Cmdr. Michael McCallion, the HUSAR/TF3 site commander from Toronto Emergency Medical Services, he was advised that a mine rescue required a different set of skills and expertise from a structural collapse rescue. They came to the conclusion that miners would not have the training and ability to assist with the rescue.<sup>250</sup> Staff Insp. Neadles did not contact Ontario Mine Rescue to investigate its capability and did not instruct anyone to do so.<sup>251</sup> When asked why he had not pursued this option, he explained:

[A]gain, from what I knew, I did not have the understanding that they would have the safety training that would permit them to enter a structural collapse.

Secondly, for me, sir, it was pretty much a red herring, because not that I ... didn't want them. I would take anyone who was accredited to assist us. But [at] that point in time, that was something that ... would have to come through some other folks to be approved anyway. So I didn't have the time at that moment to say ... I needed to go talk to Chief Officer about mining; I didn't quite have the opportunity to do that.<sup>252</sup>

Staff Insp. Neadles agreed that, at this time, although he was busy, little was happening on the site, and he could have tasked another member of his team.<sup>253</sup> Mr. Davidson then brought this portion of the conversation to a close by telling everyone they needed to get off the phone and begin developing a plan.<sup>254</sup>

Mr. McGuinty testified that he felt the call had been a success. He thought the rescue team was going to explore a new option, and that they had put together the makings of a Plan B that would bring in heavy equipment.<sup>255</sup> Mr. O'Leary's understanding of next steps was the same: the senior emergency officials, along with the on-scene responders, would be working together to restart the rescue operation.<sup>256</sup>

In his testimony, Mr. McGuinty confirmed that he did not order the rescuers back to work. He recognized that he did not have that authority; it was an operational issue with which the premier does not usually involve himself. He believed, however, that he had the authority, and the responsibility, to convey to the team on the ground that it had to explore all the alternatives. Ultimately, the team members were going to have to use their own



judgment on how to effect the rescue, but the premier alerted them to the fact that they had to keep looking for other ways.<sup>257</sup>

Mr. McGuinty described his role in getting the rescue back up and running as “essential.” I agree with this characterization. He had no reason to believe at the time that the rescue effort would have continued without his intervention. Mr. McGuinty did not see his intervention here as being operational in nature. Rather, he used the authority of his office to compel a conversation that might not otherwise have taken place. By the end of the call, he had a better understanding of the logistical challenges and the risks associated with working within the collapsed building, but he thought that the rescue teams had not given enough thought to a Plan B. Mr. McGuinty wanted them to understand that he would do whatever it took, and use whatever authority he had, to help pull together a plan. He told them that whatever they needed, they would get.<sup>258</sup>

In addition, Mr. McGuinty testified that the public reaction to the calling off of the rescue was not what drove him to take action, although it certainly played a role. He stated:

... I was very sympathetic to the feelings being expressed by the people of Elliot Lake, but I ... reacted as I felt I should be reacting, as Premier and somebody who is trying to inject some humanity into a very difficult circumstance[,] and to make sure that we were doing whatever we could to help out a community.<sup>259</sup>

Staff Insp. Neadles testified that he did not view the efforts of the premier as interference.<sup>260</sup> Rather, he characterized these actions as a person in authority wishing, willing, and wanting to do whatever he could to help move the situation forward. He testified that he did not feel any pressure from the premier. On the contrary, he felt relieved. He felt he was in a position to move forward with the plan they were going to put together. He was confident that the plan would get approved and that the operation would get “back into full swing.” Staff Insp. Neadles explained that he would need both Chief Officer and Mr. Hefkey to approve the plan – for the use of the equipment and for its financial implications.<sup>261</sup>

When asked whether he thought Chief Officer should have been invited to take part in the conference call with the premier, Staff Insp. Neadles testified that it would have been a good idea to have the incident commander participate in the conversation. Ultimately, as part of the Incident Management System, he would be called upon to approve the plan.<sup>262</sup> Nevertheless, when he was asked whether Chief Officer did approve the plan, he testified that he updated him only verbally.<sup>263</sup> As I discuss below, Chief Officer did not sign the plan document.

Mr. Hefkey also admitted that he should have spoken with Chief Officer and had him participate in the call. He claimed that things were moving quickly: he was told that the premier wanted to speak to Staff Insp. Neadles and asked to make it happen – which he did.<sup>264</sup>

Following the call with the premier, Mr. Hefkey, Mr. Davidson, and Staff Insp. Neadles took part in a conversation to discuss the next step – the development of a plan of action following the reassessment of the situation.

Mr. Davison and Mr. Hefkey informed Staff Insp. Neadles that he should not hesitate to contact them for anything he needed.<sup>265</sup>

### Conclusion on call with the premier

I am not convinced that Staff Insp. Neadles and the HUSAR/TF3 team had an alternative plan in place or that one was actually being developed at the time of the conference call with the premier. By then, Staff Insp. Neadles had had only a very short conversation with Sgt. Glavin about the possibility of using Priestly's equipment. Priestly had yet to be contacted. It was not clear that its equipment was available, let alone capable of assisting the response team on the ground.

I find that Premier McGuinty's actions and those of his staff were appropriate, responsible, humanly genuine, and warranted in the circumstances. They properly concluded that the response team must consider all possible alternative options and resume the rescue, even if the chances of success were slim. Their intervention led to a renewed sense of urgency and determination. The premier's leadership had re-energized and encouraged the emergency response teams. It also provided much needed reassurance to the public and to the families that they had the whole-hearted support of senior officials in the provincial government. In short, it gave renewed hope.

## **The premier speaks to Mr. Mantha, the mayor, and the prime minister to advise them that Plan B is in motion**

### **The premier's news appeases the community**

After his conversation with Staff Insp. Neadles, Premier McGuinty spoke to Mr. Mantha, who described the climate of frustration in the community and the urgency of restarting the rescue efforts. Mr. Mantha felt it was important to explain to the premier the history between the community and the Mall: he would then have a better understanding of why feelings ran so high. The premier told him that he had had follow-up discussions with the rescue team and that he had suggested to them that if there was a 1 or a 10 percent chance of somebody being alive in the Mall, he wanted to make sure that all efforts were made to get to that person. He also told Mr. Mantha that they were going to bring in heavy equipment and put in place a Plan B – something new that was fraught with risks. As Mr. Mantha testified, this news gave him “an overwhelming sense ... of happiness.” Mr. McGuinty thought Mr. Mantha was eager to speak to the community and inject some hopefulness into an atmosphere that was otherwise characterized by despair.<sup>266</sup>

**Mr. Mantha ran as quickly as he could to city hall to let people know that the rescue efforts were back on track. He wanted to bring some of the frustration level down.**

Mr. Mantha ran as quickly as he could to city hall to let people know that the rescue efforts were back on track. He wanted to bring some of the frustration level down. Although Mr. Mantha did not have the details of the steps being taken by the responders, for him “the important thing ... was that the rescue efforts were starting up again, and that is what the community needed to hear.” Mr. Mantha's announcement appeased the group of people that had gathered following the news of the rescue being stopped. He did not speak directly to the victims' families, but he shared the news with relatives of the victims who were present. The mood in the community improved.<sup>267</sup>

That evening, Mr. Mantha made himself available, walking on the street, listening and talking to people. He found they were extremely happy that the rescue efforts were back on and moving ahead. He gave this message to everyone: “[B]e patient. These are the professionals. They know what they are doing. Equipment is coming ... It is going to take some time, but it is moving ahead.”<sup>268</sup>

### **The premier informs the mayor of Plan B and asks the prime minister to make the army available if necessary**

Mr. McGuinty next spoke with the mayor. He told him about the phone call with Staff Insp. Neadles and described the basics of what had unfolded and what he expected would happen. Mayor Hamilton seemed relieved. Mr. McGuinty got the sense he was very concerned about his community and how people were reacting to the news of the rescue operation being shut down.<sup>269</sup>

Later that evening, at approximately 10:00 p.m., Mr. McGuinty called the prime minister to bring him up to date on what was happening in Elliot Lake. He also asked him to make the Canadian Armed Forces available at the earliest opportunity should personnel, equipment, or expertise be needed. The prime minister was very supportive.<sup>270</sup>

### 8:30 p.m. – Community Control Group meeting: “We are back on”

The Community Control Group (CCG) met at 8:30 p.m., while the conference call between Premier McGuinty and the rescuers was in progress. The purpose of the meeting, which was not originally planned, was to try to “expedite authority to demolish to recover bodies.”<sup>271</sup> As I describe elsewhere, the earlier meeting at the police station between members of the MOL, the OPP, the City of Elliot Lake, and the Office of the Fire Marshal had concluded that it appeared that no one had the authority to require that the building be entered or demolished in order to remove the victims.<sup>272</sup> Mayor Hamilton testified that stop-work orders had been alluded to, and the group was determined to find a way to get into the building as quickly as possible.<sup>273</sup> Consideration was being given to any potential authority that the City might have to get into the building expeditiously, but also as carefully as possible, given the presence of victims. The group realized that it did not have the necessary equipment, and Staff Insp. Neadles had made it clear that HUSAR/TF3 did not have the “wherewithal or the equipment to continue.” Mayor Hamilton testified that they were also trying to contact the owner’s lawyer, Antoine-René Fabris, to see whether Eastwood would object to the rescuers entering the building without legal authority.<sup>274</sup>

Chief Officer testified that although it was difficult to attempt a rescue with heavy equipment, they were still hoping it could be done. He said that the evidence from about 12 to 14 hours earlier indicated that a live person was trapped in the rubble. He stated: “I mean, your head would say no, but your heart would say keep going until you get to the floor.” He also explained that they were trying to “expedite” the authorization or the legal authority to demolish the site because

we still thought that if we could move forward fast enough, that you never know and you might have a chance of saving that person. I mean, we didn’t know that they were not deceased, so we moved it forward on that basis. We got to move it forward anyway, one way or the other ... and that was the direction we tried to do it.<sup>275</sup>

Chief Officer also confirmed that the private ownership of the Mall posed a unique problem, which was discussed at the meeting.<sup>276</sup> The notes of the meeting recorded the following statement: “EMO asked to contact their Commissioner about legislative options to take control of taking down the bld for recovery. If not a provincial emerg then no action.” Chief Officer explained that he was advised by the Office of the Fire Marshal that, as the incident commander, because he had never declared the operation a recovery, he still had control over the scene.<sup>277</sup> Chief Officer agreed that Staff Insp. Neadles had declared the operation a recovery, but it was his own declaration on a change of status, yet to be made, which governed.<sup>278</sup>

During the meeting, Mr. Thorpe, an adviser from the Office of the Fire Marshal, suggested that if the escalator came down, the search area would be considered safe for rescue efforts. He asked whether there was a controlled way to take it down.<sup>279</sup>

The notes of the meeting also record someone asking whether the community had accepted that there were two deceased individuals.<sup>280</sup> Chief Officer testified that he did not know what the response had been to that question.<sup>281</sup>

It was also noted during the meeting: “If we start picking at bld. the beams will more than likely come down. Send equipment in, not people. If weight was dropped on escalator – we could then shore / remove debris w bobcat. Attempting would be our last effort – exhausted all possibilities – approach family?”<sup>282</sup> Chief Officer confirmed that lowering the escalator would be the final possible rescue attempt: once they started to knock it down, they did not know what would happen.<sup>283</sup>



When asked whether there was discussion about lifting the escalator with a crane, Chief Officer explained that one problem was the weight, with the two sets of escalators pancaked on top of each other.<sup>284</sup> He also explained that the other issue was the reach, because the further a crane has to reach, the less it can lift.<sup>285</sup> When asked whether the slabs that had fallen on the escalator pair could be lifted, Chief Officer explained they could not, because someone would first have to get on top of the slabs to secure them.<sup>286</sup> The danger resided in the possibility that either the front of the building, and consequently the penthouse on top of the stairs, or the sides of the building would be pulled down if the escalators were to give in.<sup>287</sup> Chief Officer testified that this discussion did not take place at the CCG meeting but likely among the engineers.<sup>288</sup>

Chief Officer testified that several individuals came forward with suggestions. One suggestion was that they take big blue dumpsters, flip them upside down, and slide them underneath the front of the building as some kind of shoring.<sup>289</sup>

Staff Insp. Needles arrived at the meeting at approximately 9:00 p.m.<sup>290</sup> He told them: "We are back on." The notes of the group meeting indicated:

Bill Needle [*sic*] arrived  
Dan Hefkey, Premier Dalton McGuinty  
Plan to go in  
Will send whatever we need.<sup>291</sup>

Staff Insp. Needles provided the attendees with a brief description of the telephone conversation he had had with the premier. He announced that they had obtained the authorization to bring in heavy equipment and to try to move the operation forward.<sup>292</sup> He explained that the "transformer," a specialized piece of equipment with a very long-reaching arm and a grappling hand, was coming to Elliot Lake and would be able to extend its arm over the roof of the Mall and secure the escalator.<sup>293</sup>

The notes of the meeting then record the following statement: "It still is a rescue. We should say it is a recovery."<sup>294</sup> Staff Insp. Needles testified that he did not believe these words were his. In his mind at the time the operation was now a recovery; in his heart it was not.<sup>295</sup>

The notes of the meeting then go on to record the following comments:

Efforts to continue – resume  
Operation is back on  
Follow protocol  
Get media another  
Press conference @  
Civic centre  
Announce = successful in obtaining  
Permission for recovery  
Stress – last ditch effort.  
Premier = full support<sup>296</sup>

Staff Insp. Needles advised the group that this effort was certainly the last one. He also warned that, despite these efforts, in all likelihood (90 percent chance) the escalator could still fall.<sup>297</sup>

Ms. Bray, who took the notes, testified that the phrase “efforts to continue – resume operation is back on” referred to the fact that the operation had been called off as far as the CCG was concerned, but that it was now moving ahead.<sup>298</sup>

When asked whether he thought it was probable, in light of the new plan, that somebody would be recovered alive from the scene, Mayor Hamilton testified:

Well, what I can say is my head said not likely; my heart said let’s give it a shot, because whenever there is a chance, you have got to take it, but I don’t think anybody was under any misconceptions that this was a long shot.<sup>299</sup>

At 9:20 p.m., after the completion of the CCG meeting,\* Ms. Bray, Mr. Ewald, Chief Officer, and Mr. Jeffreys met with Mr. Fabris to discuss obtaining the owner’s permission to expedite the process of getting into the building. There had been an indication that it might take a week for the owner to get an engineer on site. Mr. Fabris advised them that they had full authority to proceed in any way they needed, and he signed the following authorization:

June 25/12

9:20 pm

I Antoine-Rene Fabris solicitor for Eastwood Mall Inc. have full authority from the owner Robert Nazarian to allow emergency services to perform whatever work demolition necessary to continue the rescue or recovery process

[signature of Mr. Fabris]

Antoine-Rene Fabris

[signature of Ms. Bray]

Natalie Bray<sup>300</sup>

### 8:30 p.m. – Mr. Cranford is told not to return to Elliot Lake

Mr. Cranford and Dr. Feldman had left Elliot Lake after the briefing from Staff Insp. Neadles and were listening to the media reports on the car radio. Mr. Cranford testified that he heard quite a few reports, including some saying that people felt things had been wrapped up too soon, that more needed to be done, and that a new plan was being considered to continue the work. He said he also thought he heard in the news report that a telephone call had taken place with the premier.<sup>301</sup> As a result, Mr. Cranford contacted Capt. Comella at 8:30 p.m. to see whether he was needed in Elliot Lake. He advised Capt. Comella that they could come back because they were not far away. Capt. Comella told him that he was not required and should continue the drive home.<sup>302</sup>

Staff Insp. Neadles was not aware that Mr. Cranford had been released. Nor was he told that Mr. Cranford had volunteered to return to Elliot Lake or asked about the possibility of having him return. He testified that he would have found a role for Mr. Cranford had he stayed. His departure left the HUSAR/TF3 team without a dedicated engineer.<sup>303</sup>

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\* There was some suggestion by Mr. Jeffreys during his testimony that the meeting with Mr. Fabris took place before the CCG meeting (Jeffreys testimony, October 3, 2013, pp. 28173–4 and 28194). However, the note signed by Mr. Fabris clearly indicates the time of 9:20 p.m., leading me to believe that the meeting with Mr. Fabris took place after the meeting.

### 9:00 p.m. – HUSAR/TF3 keeps busy

Capt. Comella testified that while they were waiting for Staff Insp. Neadles to return, the responders were “doing as much as they could to stay engaged waiting for ... that go-ahead.”<sup>304</sup> At 8:45 p.m., Capt. Comella asked Chris Rowland, a member of the HUSAR/TF3 team, to put laced-post shores underneath the walkway on the Zellers side of the building. According to Mr. Rowland’s notes, the shoring operation began at 9:00 p.m.<sup>305</sup> Capt. Comella testified that they set these posts up because they had no way of knowing how much the vibration was going to affect the building. Yet, at this time, no authorization had been given for the use of the Priestly crane.

Capt. Comella could not recall if he met with Staff Insp. Neadles between 2:20 p.m. and 8:45 p.m., but he did not think so. He believes he probably slept during that period. He does not recall meeting with Cmdr. McCallion during that time either. Capt. Comella testified that he was never told the operation was not a rescue, so he was working on the assumption that it still was, although he agreed the workers could not go into the hot zone. He testified that the next thing he can recall being told, on June 26 at 2:30 a.m., was that they had received the approval to bring in the heavy equipment.<sup>306</sup> Given that Capt. Comella was the operations chief in charge of conducting the rescue, I am surprised that he would not have been made aware of this important development. This omission is further evidence of the lack of communication among members of the HUSAR/TF3 team.

At approximately 9:30 p.m., Capt. Comella noted the following conversation he had with Capt. Martin McRae, a HUSAR/TF3 training captain with the Toronto Fire Department: “Discussed with Marty what is needed in anticipation of heavy equipment. Clear top of parking area / access road cleared / lighting in place.” Capt. Comella testified that he had several conversations about cleaning up, moving equipment, and getting ready for the next steps of the operation. He explained that the footprint for the heavy equipment was very large. Consequently, they needed to clear the parking area south of Foodland to be able to bring the equipment up as closely as possible. They also cleared the access road (driveway leading up to the roof parking of the Mall) because they were not sure exactly how Priestly was going to get that enormous piece of equipment close to the building. They were trying to anticipate what was going to happen. They also set up lighting, using portable lights, where they knew they could light up the building and the work area.<sup>307</sup>

### 9:00 p.m. – Mr. Cranford is advised to return, and then not to return, to Elliot Lake

At approximately 9:00 p.m., Mr. Cranford received a telephone call from Cmdr. McCallion advising him that there was a new course of action and that they needed him to return to Elliot Lake. At that point, Dr. Feldman and Mr. Cranford were near Parry Sound. Dr. Feldman was unable to drive Mr. Cranford back to Elliot Lake. Arrangements were therefore made with Cmdr. McCallion to have Mr. Cranford dropped at the OPP detachment in Parry Sound and for the OPP to drive him to Elliot Lake.<sup>308</sup>

At 9:30 p.m., Mr. Cranford and Dr. Feldman arrived at the Parry Sound OPP detachment. Mr. Cranford contacted the site in Elliot Lake and spoke to Capt. Comella or Cmdr. McCallion. Despite advising that he was willing to go back, he was again told he was not needed – they had everything under control, and he should simply go home. The Parry Sound OPP officer also confirmed this information through his own channel.<sup>309</sup> Mr. Cranford left with Dr. Feldman and arrived home in Toronto at 2:00 a.m.

Staff Insp. Neadles testified that he was not aware of these communications with Mr. Cranford until sometime after 9:30 p.m.<sup>310</sup>

I find the release of Mr. Cranford from his duties at this early stage rather odd. I would have thought that a team still intent on proceeding with a rescue operation would require the assistance of an engineer to provide them with advice, particularly when it had been determined that the building was shifting. In my view, this



decision was consistent with the rescue team abandoning hope of a rescue and moving to the recovery phase. In addition, the fact that Staff Insp. Needles was not consulted is further evidence of the lack of communication among members of the HUSAR/TF3 team.

### **9:00 p.m. – Staff Insp. Needles advises Mr. Sanders that the rescue is back on**

At approximately 9:00 p.m., Brian Sanders saw Staff Insp. Needles and spoke to him briefly. After ascertaining that he was the regional engineer, Western Region, from the MOL, Staff Insp. Needles instructed him to follow him into the command tent. Staff Insp. Needles advised him: “It’s back on. Premier’s order.” Following his conversation with Staff Insp. Needles, Mr. Sanders sent an email to Mr. Jeffreys, who was attending the 8:30 p.m. CCG meeting, in which he stated: “Premier’s order. Call me immediately.” Mr. Jeffreys did not call Mr. Sanders back in response.<sup>311</sup>

Mr. Sanders testified that he was never advised that the rescue should be shut down. He was also not aware if it was ever the intention of anyone from the MOL to shut down the rescue operations. He never issued such an order.<sup>312</sup>

### **10:01 p.m. – Ms. Chambers warns team against possible confusion over who holds the position of incident commander**

At 9:17 p.m., Mr. Thorpe advised Carol-Lynn Chambers, manager of emergency planning and strategic development in the Office of the Fire Marshal, Ministry of Community Safety and Correctional Services, that the premier had spoken to the mayor and that “he has stated to go ahead and do what has to be done!” This message was the first indication Ms. Chambers had that things were moving forward. She testified that she had spoken to Staff Insp. Needles earlier that evening, but he had simply informed her then that he would be speaking to Mr. Hefkey later in the evening about another plan.<sup>313</sup> Ms. Chamber responded to Mr. Thorpe, requesting a briefing and asking whether HUSAR/TF3 was resuming.<sup>314</sup>

At 9:45 p.m., she also sent an email to Staff Insp. Needles, asking him to keep her informed because she now seemed to be receiving conflicting information from Mr. Thorpe.<sup>315</sup> She wanted to speak to Staff Insp. Needles to find out what was happening at that time. She did speak to him, and he provided her with information that she included in her 9:56 p.m. update, discussed below.<sup>316</sup>

At 9:50 p.m., Mr. Thorpe responded to Ms. Chambers, advising her:

Correct? ... The plan is that the MOL has no issue if the escalator is dropped. Therefore, the plan, as I know it, is to use strictly mechanical means with no human entry into the structure and force the escalator to drop.

The MOL engineer will then inspect, and when and if deemed safe, will permit the work to continue.

It is important to know that this operation is a continuation as a rescue ... It has not been transferred as a recovery to this point in time.<sup>317</sup>

Ms. Chambers responded with the following message to Mr. Thorpe and Brent Ellen, a program specialist in the Office of the Fire Marshal: “Suggesting FC [Fire Chief] keep control, order IAPs [incident action plans] from HUSAR/UCRT, get a well-articulated strategy out of both and inform EOC [Emergency Operations Centre] so that they can preplan the communications plan and statements. This is still the fire chief’s scene.”<sup>318</sup>

Ms. Chambers testified that she wanted clarity above all. By making these comments, she wanted to make it clear that the fire chief was still, as far as she knew, the incident commander. She further explained that an incident action plan provided clarity to all parties involved with the response. There had been numerous communications from different channels. She was, therefore, simply suggesting that the single point of contact, the single incident commander, be clarified as being the fire chief. The scene was still his, and he needed to be involved.

She also wanted coordination and alignment so that the messaging was consistent with the operations. In her view, it was very important that everyone be on the same page with respect to the next steps in the mission. It was also important that the incident action plan clearly outline for the incident commander and others what the plan would be going forward.<sup>319</sup> Ms. Chambers testified that the plan did not have to be typed; it should, however, be written in some way so that it was clear to all the parties involved. She confirmed that she had not seen, and was not aware of, any incident action plan before this point.<sup>320</sup>

At 9:56 p.m., based on the conversation she had with Staff Insp. Neadles and the information given to her by Mr. Thorpe, Ms. Chambers provided a further update to the fire marshal and to senior officials within his office:

Further to my update below,

MOL has been provided direction to consider an alternate course of action. Specifically the re-examination of an alternative method of securing or removing the specific hazards that prompted MOL engineers to issue the STOP WORK order declaration. Once an approved plan has been designed the implementation of that plan can begin and HUSAR assets will commence their efforts.

OFM is continuing logistic support for responders and local liaison.

UCRT has been requested to provide POU support as there is significant concern at the local level that there may be civic disobedience in the immediate area.

Further update/detail to follow once the work plan has been approved. t [sic] is important to know that this segment of the operation is being deemed RESCUE.<sup>321</sup>

At 10:11 p.m., Ms. Chambers informed the EMO duty officer that a new plan was being developed. Tom Kontra, who worked for the Office of the Fire Marshal, responded: "Did this get pushed up from us or someone else? The last U saw was their planned withdrawal, so this is a major (good) change." Ms. Chambers responded:

Long story, involving implications of MOL's order limiting any further activity or recovery ops.

Communication and jurisdictional issues locally in the mix as well.

Suffice to say this was a good outcome in the short-term and may help quell some of the public outcry and perhaps still some hope for one trapped person. Engineers came back to the table and HUSAR is engaged.

Ms. Chambers explained that she had read a media report that the MOL was closing the building. She understood at the time that, when the operation moved to a recovery, the ministry would be making an order to close the building. She explained that there seemed to be a disconnect between what was being reported in the press and what was actually happening. Until that time, she thought she had streamlined communications, but now there were gaps where she was not aware of what was happening. As for the jurisdictional issues, she was referring to what would happen in the event of a recovery: Would the fire chief retain jurisdiction? Would it become a MOL issue?<sup>322</sup>

### **10:20 p.m. – The premier releases a statement: He has instructed the rescue team to determine if there is another way to reach the victims**

At 10:20 p.m., the Premier's Office released the following statement:

Ontarians have been hoping and praying that rescuers could reach any survivors in the rubble of the collapsed Algo Mall in Elliot Lake.

Today, we learned that the remaining structure has de-stabilized further. Authorities on the scene believe it has become extremely difficult to predict whether it may collapse and that further rescue efforts could endanger the lives of the rescuers.

*I have spoken to Emergency Management Ontario and the Heavy Urban Search and Rescue Team and have instructed them to determine if there is any other way possible to reach any victims without endangering our rescuers, including the use of equipment to dismantle the building from the exterior.*

I believe we owe it to the families waiting for word of their loved ones to leave no stone unturned. We owe that to the people of Elliot Lake too. Ontarians expect nothing less.<sup>323</sup> [Emphasis added.]

Mr. McGuinty testified that the use of the word “instructed” was deliberate. He wished to convey in the strongest possible way, without crossing the line into operations, that he wanted the people on the ground to use their own judgment and make a determination as to whether there might be something else they could do to get to the victim or victims. The dismantling of the building from the exterior was a reference to Plan B, which had been discussed during his call with Staff Insp. Needles. Mr. McGuinty testified that he was also, through this statement, encouraging the responders to bring out a plan C, D, E, or F if they had one, but to keep trying.<sup>324</sup>

At 11:05 p.m., Ms. Conrad emailed Mr. O’Leary and others:

I just got off the phone with mcscs officials. Here’s what’s going on:

- OPP will send a media person up first thing tomorrow morning
- MCSCS will also send someone to provide media support and coordination
- EMO is working with the MOL engineer to develop a plan to continue the search based on first responder safety and one that causes the least destruction
- Priestly Demolition has been contacted and may be on route from Sudbury because they have larger equipment and they have worked with HUSAR in the past on rescue ops
- Dan is calling the feds to ensure they are ready to deploy if we need assistance
- Vale Inco – has offered equipment and any other resources as needed but will not send equipment in if civil engineers say it is unsafe. They are also trying to track down a mining engineer
- OPP incident commander on site for security issues
- Dan will be going up at 5 tomorrow morning

I will be on another call at 8 am with the same group.<sup>325</sup>

Mr. O’Leary testified that he had not heard of Priestly Demolition before he received this email, although reference to heavy equipment had been made during the conference call with the premier.<sup>326</sup> He explained that, following this conference call, a number of the provincial agencies worked quickly and closely to develop this plan.<sup>327</sup> It is also apparent that, after this conference call, the various provincial agencies made a more concerted approach to work together.

### **End of the day – The MOL issues an order to the owner to obtain an engineering report and to forbid access to the Mall to workers (excluding the rescuers)**

Later the evening of June 25, following the resumption of the rescue,<sup>328</sup> Don Jones, an inspector with the Ministry of Labour, prepared a field visit report and issued the following three orders to Eastwood Mall Inc.:

- a requirement that an assessment of the structural integrity of the Mall be conducted by an engineer;
- a requirement that safeguards be put in place to prevent workers from accessing the building; this requirement excluded specifically “activities associated with rescue / recovery operations or to structural evaluations by a Professional Engineer”; and
- a requirement that the workplace be cleared from workers and isolated by barricades / fencing to prevent access by a worker until the danger has been removed; this requirement excluded specifically “activities associated with rescue / recovery operations or to structural evaluations by a Professional Engineer.”<sup>329</sup>



These orders were the only ones issued by the MOL between June 23 and June 25.

Mr. Jones testified that he sought the assistance of Mr. Jeffreys for the reference to engineering work. He then sent it for review to Legal Services in Toronto. He was advised by Legal Services around midnight that it had no changes or suggestions.<sup>330</sup>

When asked why the orders were issued at that time, Mr. Jones testified that, as part of his role, he had to deal with the owner of the premises and was required to provide the owner with some guidance of what the ministry expected. When he first arrived on the scene, the rescue was in full force, and he did not know who owned the Mall. By June 25, he knew who the owner was and knew that the Mall manager was available to receive the order.<sup>331</sup> Mr. Jones testified that the stoppage of the rescue (which he learned about at the 3 p.m. CCG meeting) was not his motivation for issuing the orders at that time. He explained that the orders would have been written whether the rescue had continued or not.<sup>332</sup>

The field visit report and orders were served on Rhonda Bear, the Mall manager, on June 26.<sup>333</sup>

### 11:56 p.m. – Plan B is being developed

Following the conference call with the premier, Capt. Comella, Sgt. Glavin, and Mr. Jeffreys worked with Staff Insp. Neadles until midnight on the details of Plan B.<sup>334</sup> Sgt. Glavin confirmed that, at some point in the evening, he spoke to Capt. Comella about the Priestly equipment. He believed that Staff Insp. Neadles was also present. Given that Capt. Comella was unaware of the existence of such equipment, Sgt. Glavin described how the machine worked and how they could manipulate its articulated arm. Capt. Comella began asking how they should prepare the site, how big the equipment was, and how much of a footprint it would require. Capt. Comella devised a plan for raising the entire area outside the front doors of the Mall. By raising it with blast rock, it would increase the equipment's reach and give it more room in which to work.<sup>335</sup>

At 11:56 p.m., Staff Insp. Neadles called Mr. Hefkey to explain they had the outline of a plan that involved Priestly, a company they had used in the Bloor Street collapse.<sup>336</sup> According to Staff Insp. Neadles, the plan at the time, which he shared in its entirety with Mr. Hefkey, was as follows:

- A. Give or take a couple of final tweaks, but the intention was to have them [Priestly] bring up the – [Komatsu] 850 I believe is a very large crane that has an extended boom [that] ... can reach up to 125 feet, and then it has an articulating arm that can bend down with also a knuckle that can turn at the bottom. The intention of the first part was that if this arm could reach up and extend down, put itself on the floor, and it had the ability to just take the entire escalator with the slabs and just move it backwards and make it a controlled fall and move it out of the way, away from the pile, away from all the victims in another direction. I believe they were going to – and I don't know the directions, but they were going to move it away from the victims.

If that would not work, the other plan was as we went to after, because that was not capable, the knuckle was – or the arm was – it just didn't fit in the hole in the roof properly or it didn't quite make it. The next part, plan to that was to precisely take out the corner of the Mall, and we saw that and they did that with very distinct precision, and then they would move in and ... remove the escalator.<sup>337</sup>

Referring to a photograph in Exhibit 7924, Staff Insp. Neadles further explained that the plan was to have the arm go over the top of the penthouse and then extend down inside the building to the floor, or down to an area close to the floor (fig. 2.6.1). There it would forcefully, and in a controlled manner, push the escalator down and back, away from the location where the victims were located. By then, the dangerously fallen beam had been removed. In devising this plan, Staff Insp. Neadles testified that he had not personally contacted Mr. Priestly.<sup>338</sup>

Mr. Hefkey recorded in his notes that the team still needed to work on confirmation, though it was leaning toward this solution. He himself concurred with the plan. He testified that Staff Insp. Needles advised him that the responders thought Priestly could add some value to the operation, and that Staff Insp. Needles was now attempting to confirm its availability.<sup>339</sup>

During his testimony, Mr. Hefkey clarified that his approval was not required and that Staff Insp. Needles could have ordered the crane on his own; he had the authority, despite the significant cost involved. Mr. Hefkey admitted that this authority should have been made clear to Staff Insp. Needles: it certainly constituted a lesson learned

for the future. As he testified, “The matter of finances should not be the impediment or the hurdle that would either delay or stop any kind of an operation.”<sup>340</sup> That being said, financial considerations do not appear to have influenced Staff Insp. Needles’s decision with respect to the Priestly crane: he testified that he did not discuss the cost of the new plan with Mr. Hefkey or Mr. Priestly when it was approved.<sup>341</sup> This point was corroborated by the evidence of Sgt. Glavin and Mr. Priestly, who both testified that the issue of costs was not discussed during their conversation leading to the deployment of the Priestly equipment at 1:46 a.m. on June 26. Sgt. Glavin further testified that no one asked him to inquire about the cost of using the Priestly equipment – and he did not.<sup>342</sup>



**Figure 2.6.1 Concrete slabs and cement blocks laying on top of the slabs**

Source Exhibit 7924

## **June 26–27 – The resumption of the rescue: more akin to a “recovery”**

What ensued on June 26 was a renewed sense of urgency and determination to rescue the victims, despite the slim chances that they were still alive. Although there is no doubt that the responders were still hopeful to a degree, their actions in some respects were more consistent with those of a recovery operation.

### **1:36 a.m. – Call between Staff Insp. Needles and Mr. Hefkey: “authorization” to proceed with Priestly**

At 1:10 a.m., Ms. Chambers contacted Staff Insp. Needles at his request. He explained that there had been a meeting with senior government officials to decide next steps and that he had been directed to develop an alternative operational plan that Mr. Hefkey would then review and approve.<sup>343</sup> Ms. Chambers agreed that it was unusual for the commissioner for community safety to have to approve an operational plan or an incident action plan.<sup>344</sup>

At 1:36 a.m., Mr. Hefkey spoke to Staff Insp. Neadles. Mr. Hefkey made notes of the call:

Returned call from Bill Neadles. They have a plan that they have worked on through the evening.

He wants it to be safe for all concerned and we agreed that it should be least destructive. Yes he has had input from the HUSAR embedded engineer as well as the MOL engineer. There are no engineers who wish to take this on.

Priestly Construction is available and ready to deploy. There are pieces that will come from their Toronto / Aurora site and some from Sudbury. 3 pieces total. Bill is being told that they will leave a.s.a.p. but should roll into town by 1400hrs.

Bill has a TPS unit escorting the crane up the Hwy from Aurora

I explained to Bill that he had our support and authorization to actualize.

Also shared that we have a piece of kit from penguin [*sic*] (Penguin Solutions, a mining equipment company in Sudbury) that might be of use and he will have his folks receive the Penguin team and see how it may be used.<sup>345</sup>

Staff Insp. Neadles testified that he did not want the plan to inflict any injury on the victim should she still be alive.<sup>346</sup>

Despite Mr. Hefkey's note, Staff Insp. Neadles had not received input from the "HUSAR embedded engineer," Mr. Cranford, who, as I describe above, had already received clearance to leave Elliot Lake. Mr. Hefkey, however, testified that Staff Insp. Neadles had referred to the HUSAR/TF3 embedded engineer.<sup>347</sup> Mr. Cranford testified that he was not asked for his opinion or input after he left Elliot Lake, and that he was not aware of the plan discussed in these communications.<sup>348</sup>

Staff Insp. Neadles testified that he did not know anything about the reference in Mr. Hefkey's notes to the phrase "no engineers ... wish to take this on." He explained: "I'm thinking that would be a tough call for an engineer, and I am not sure if we are referring to a new one, one of ours or even Mr. Cranford or Mr. Jeffreys. I'm not sure if that was part of a conversation we were ... talking about [ – ] an engineer may not want to sign off on this." He agreed, however, that Mr. Jeffreys was actively participating in the process, and that Mr. Cranford was prepared to come back to assist.<sup>349</sup> Mr. Hefkey testified that he could not remember what Staff Insp. Neadles meant by this remark other than that they were talking about a structural collapse situation and that engineers were not going to want to "put themselves out there," given the situation and how risky it was.<sup>350</sup>

Mr. Hefkey testified that he was not surprised at the length of time it would take Priestly Demolition to deploy to Elliot Lake.<sup>351</sup> Furthermore, he was not surprised that it took approximately four hours from the conference call with the premier at 9:30 p.m. for a decision to be reached to engage Priestly. In Mr. Hefkey's understanding, given that the Mall's façade was still intact, it took time to confirm that the company actually had the equipment that was required, and that it was available. Mr. Hefkey assumed that a number of conversations back and forth with Priestly went on throughout that evening, to determine what it had and how it intended to proceed.<sup>352</sup>

Staff Insp. Neadles also confirmed that Mr. Hefkey gave him the approval to proceed with the Priestly team.<sup>353</sup> Although Mr. Hefkey clarified that Staff Insp. Neadles did not need his authorization, he testified that he used the word "authorization" because Staff Insp. Neadles was supposed to keep him informed about whatever plan was being implemented. Mr. Hefkey agreed, however, that there was a difference between keeping someone informed and seeking his authorization. He also agreed that it was reasonable to conclude that Staff Insp. Neadles thought he needed Mr. Hefkey's authorization, and that Mr. Hefkey was providing him with it. He stated, however, that his authorization was not really necessary.<sup>354</sup>



Although approval of Plan B by Mr. Hefkey may not have been required, it is clear from the evidence that Staff Insp. Neadles thought it was. One can speculate that this idea could have resulted from the negative reaction Staff Insp. Neadles faced after the decision to stop the rescue, and that he was now looking for Plan B to be sanctioned by higher officials.

## Plan B: Priestly Demolition is engaged

### 1:46 a.m. – Confirmation to Priestly of deployment

At 1:46 a.m., after receiving instructions from Staff Insp. Neadles,<sup>355</sup> Sgt. Glavin called Mr. Priestly to confirm that Priestly Demolition was being deployed.<sup>356</sup> The timing is confirmed in an email from Mr. Priestly to his team.<sup>357</sup>

Unlike the evidence of Mr. Priestly and Sgt. Glavin, Capt. Comella testified, relying on his notes, that the decision to go ahead with Priestly came at approximately 2:30 a.m. Indeed, Capt. Comella testified that he recalled he was eating with Staff Insp. Neadles at the time the approval came.<sup>358</sup> In this regard, I am inclined to agree with the evidence of Mr. Priestly and Sgt. Glavin because of the contemporaneity and precision of the recording of the information.

Given his understanding that this effort was still a rescue operation, and the fact that he was first contacted at approximately 8:00 p.m., Mr. Priestly testified that he believed the response team could have been more expeditious in deciding to deploy his heavy equipment.<sup>359</sup> Even Capt. Comella, who claimed that he knew the decision would take some time because it would have to go to a higher authority, thought it took much longer than he had anticipated.<sup>360</sup>

### 2:45 a.m. – Mr. Priestly advises of requirements for equipment

At 2:45 a.m., Mr. Priestly emailed Sgt. Glavin describing the equipment to be used for the operation. He stated:

As requested he [*sic*] equipment requested for the project is as follows:

1. Komatsu PC 850 with 150 of reach. The machine has a shear attachment.

This machine is 3 loads. The base machine needs an escort which we can escort or use a police escort we should double check the route to make sure we can move it thru construction routes etc.

2. Link Belt 460 with second member shear.

3. Komatsu PC 490 with grapple.

Machine 2 + 3 are in sudbury [*sic*] and can be there in a couple hours notice. The big machine is in our yard and will be about 6 hours travel time as it is heavy and takes a while.<sup>361</sup>

Mr. Priestly testified that the Komatsu 850, also referred to as the high-reach machine, is custom built for demolition. It can reach 150 feet vertically when its arm is extended straight up. It had the most height of any demolition machine in Ontario and had been used in the World Trade Center disaster. In addition, a variety of attachments could be connected at the end of its arm, such as a rotating grapple, a rotating shear, and a concrete crushing jaw. Mr. Priestly explained that, ordinarily, this machine was used to tear down high structures. He said that he did not believe he had used it in any of the recovery operations he had been involved in, given its very cumbersome transportation requirements (figure 2.6.2).<sup>362</sup>



**Figure 2.6.2 The Komatsu 850**

Source Exhibit 7950



**Figure 2.6.3 The Link Belt 460**

Source Exhibit 9899



**Figure 2.6.4 The Komatsu PC 490**

Source Exhibit 9900

Mr. Priestly testified that the Link Belt 460 has a shear attachment and was predominantly used to process thick steel (it is able to cut a one-inch plate) and to tear down steel buildings. It was also used to take down concrete bridges, because it was able to cut rebar. Although it did not have the reach of the Komatsu 850, the machine was able to extend over 30 feet (fig. 2.6.3).<sup>363</sup>

The Komatsu PC 490, Mr. Priestly explained, is a standard excavator with a grapple. The machine could grapple all sorts of material, but it is also very precise in that it can grab a tennis ball and throw it (fig. 2.6.4).<sup>364</sup>

Mr. Priestly testified that he was asked whether Millennium's cranes would be of assistance. He said no, because he believed he could use his own machines. The Priestly team would also bring its service truck, which contained rigging equipment (such as chain links, wire rope slings, and a chain spreader).<sup>365</sup>

In his testimony, Mr. Priestly stated that Sgt. Glavin had asked him what the response team could do to set the scene up for the arrival of the Priestly equipment. He advised him that they could build a gravel pad outside the building. Mr. Priestly explained to him that the high-reach machine could not work on a slope or on ground that was not level.<sup>366</sup> He informed Sgt. Glavin that the machine was not only heavy but wide, and that access for it would have to be arranged to the site. In response to this suggestion, a gravel pad and other areas adjacent to the Mall were filled in to ensure that the machine could get by without damaging the curbs on the road.<sup>367</sup> Mr. Priestly also asked for a police escort – because of the size of the machine and a possible hazard for other vehicles, and also because he did not have time to obtain the requisite trip permit from the Ministry of Transport. A police escort was provided.<sup>368</sup> Sgt. Glavin spoke to Staff Insp. Needles and suggested that the four Toronto Police sergeants provide the escort, “instead of involving anybody else in making this thing not work or maybe someone not understanding the sense of urgency.”<sup>369</sup>

Sgt. Glavin did not know whether the Priestly high-reach machine had been used in rescue situations before, though he knew it had been used in recoveries. In his opinion, because heavy equipment causes vibrations, it was always best in a rescue situation to use people first, rather than machines on the ground of a collapse zone. It was best to be as gentle as possible, to do the shoring, and to bring in heavy equipment only if necessary. That was why he referred to the Priestly equipment as Plan B, as opposed to a first option.<sup>370</sup>

## 2:00 a.m. – UCRT is released from public order duty

At approximately 2:00 a.m., the UCRT team was released from public order duty and advised by Sgt. Gillespie to leave the premises: by then, the tense situation with the community had de-escalated and seemed under control. People were leaving and appeared to be feeling better about the rescue operation. The UCRT members were told to stand down, exit the Mall, and return to their hotel in Massey, approximately 65 kilometres away.<sup>371</sup> Cst. Dan Bailey, a canine handler with the OPP, testified that, at that point, they had no idea what would happen in terms of the rescue operation. Sgt. Gillespie said he would advise them as soon as he had an update on next steps. Everyone was told to get some sleep and wait for further instructions.<sup>372</sup>

## 6:00 a.m. – Priestly mobilizes team

At some point after 1:46 a.m. and before 6:00 a.m., the Priestly team started to get its machines ready for transport. The high-reach machine, which was assembled in Priestly's yard, had to be disassembled. Three tractor-trailers were required to transport it. The two other machines, in Sudbury, required two trailers.

The four HUSAR/TF3 police sergeants (Jim Lawson, Avelino Carvalho, Dave Zammitt, and Phil Glavin<sup>373</sup>) drove to Aurora to escort the high-reach machine. They waited for the Priestly team to dismantle it before accompanying it back to Elliot Lake. During transportation, local OPP officers assisted the Toronto Police sergeants with the escort from Parry Sound to Sudbury and from Sudbury to Elliot Lake.<sup>374</sup>

The Priestly team from Sudbury drove up with the two machines and arrived on site at approximately 11:00 a.m. Mr. Priestly drove up in his own truck and arrived at approximately 4:00 p.m.<sup>375</sup>

## 1:00 a.m. – 7:00 a.m.: Shoring continues

During the night, Chris Rowland and his HUSAR/TF3 team continued their work in shoring underneath the walkway at the Mall. At 7:00 a.m., Capt. Chuck Guy's team took over.<sup>376</sup>

Staff Insp. Needles agreed that the Priestly equipment was not expected to arrive until sometime in the early afternoon and that additional time would be required to assemble the cranes and actually start working. He conceded, however, that there could have been cause for concern if members of the public saw that nothing was happening on the site or that the workers were standing around doing nothing.<sup>377</sup>

Referring to the wooden laced-posts that had been constructed underneath the walkway, Staff Insp. Needles admitted that part of the reason they were built was to give the public the opportunity to see the team at work. He explained that there was no way to televise or publicize what the rescue team was doing inside the building. He conceded, however, that at that time, no one was going into the building.<sup>378</sup> He explained that, at the suggestion of Capt. Comella and Mr. Jeffreys, the shores were constructed to help with the vibrations that might emanate from the Priestly equipment and to prevent any further damage to the building.<sup>379</sup> Staff Insp. Needles was unable to comment on whether the laced-posts had been installed correctly – an issue that I describe below.<sup>380</sup>



In his testimony, Cmdr. McCallion gave a different explanation for the shoring: its sole purpose, he said, was to protect the veranda, or balcony, from vibrations. He did not agree that building the shores had any public relations motivation. He understood how this perception – that the shoring was done to show the team at work to the community – might have developed, but it was simply not true.<sup>381</sup>

Mr. Priestly testified that, because some of the beams were badly rusted, the wood shoring served as a safety factor for the people working there.<sup>382</sup>

Capt. Comella testified that although the shores were erected to

assists us in ... understanding what that whole structure was going to do and the vibration of the heavy equipment ... it certainly didn't hurt that they were doing what they could, and ... visible, I guess, to the public ... that wouldn't have hurt how the public was perceiving what was going on, but they did have a function.<sup>383</sup>

Ultimately, the reason behind the construction of the shores at that time is of little consequence. If there was a protective purpose to their erection, all the better. It is more likely, however, that the purpose of the exercise was to reassure the public that work was progressing and that recovery efforts were continuing.

## **7:11 a.m. and 7:53 a.m. – Staff Insp. Neadles sends an update to the Office of the Fire Marshal: Plan B has been approved by Mr. Hefkey**

At 7:11 a.m., Staff Insp. Neadles sent an email update to members of the HUSAR/TF3 team and to the Office of the Fire Marshal:

This is a day to remember and it is all good.

As you know that [*sic*] as of approx 3pm the Rescue Operation being conducted by the HUSAR Team were suspended due to unsafe conditions within the building.

the [*sic*] damage to the guiding caused serious structural damage to the building Lin [*sic*] the open areas near the centre of the mall.

The known victims one believed to be deceased and one who showed signs [*sic*] of life were trapped under debris approx 20-30 ft from the escalator.

The rescue was hampered by a 25 ft I beam which was twisted and hanging over the area of the Victims. The I beam was 25 ft long weighing in excess of 2500 lbs. It had to be and was removed.

There was a very large slab of concrete which fell on and remained on the escalator. This proved to be the game changer. The forces of stress put on the I beams that support the escalators began to deteriorate the integrity of the escalator and it started to push the escalator down and also separate it from the building. The stress on the structure was in excess of 100% over capacity and the lower I beam started to bow.

The integrity of the structure was now at risk of further collapse and on advice from our Team and Ministry of Labour I removed the team for safety reasons.

This as could be expected charged the community's emotions. I attended with their mayor and designated.<sup>384</sup>

At 7:53 a.m., Staff Insp. Neadles continued his email:

I believe this message was cut short.

OPP Detachment Commander to advise the family and this was not well received news.

A press conference followed which started out very ugly but at the end they appreciated the efforts of the team.

At approx 7:30 pm I was contacted by Dan Hefkey and invited to join him on a call. I was given direction by the Premier to continue to plan to continue efforts to rescue the victim as we owe them and their family every opportunity. I explained our Team's capabilities and limitations of a "Rescue" in this situation and was to compile a plan and any equipment required.

I worked with the Ministry of Labour Engineers and our people to design a plan utilizing heavy equipment to reduce the secondary structural collapse risk inside and the peel back and grapple the exterior working the 35 ft to the victims.

I had this plan and granted permission by Dan Hefkey to operationalize our plan.

Arrangements made to have this heavy equipment (3 tractor trailers) escorted from Toronto and Sudbury.

Anticipated ETA is by 2–4 pm. Work will commence to prep the site this morning by utilizing an excavator to cut a new entry to the plaza as the machine is to [sic] big to enter.

Thanks to all for the support and your respective staff also appreciate it.<sup>385</sup>

Staff Insp. Neadles testified that he wrote that he was "given direction by the Premier to continue ... efforts to rescue the victim" because it was something the premier wanted them to do. He explained that "direction" may not have been the most accurate word he could have used, but it was intended to convey that the premier was encouraging the operation going forward.<sup>386</sup>

The "limitations," he said, referred to HUSAR/TF3's inability to access the victims and its lack of heavy equipment.<sup>387</sup>

## At some point during the day, the City authorizes Priestly to be on the scene

On June 26, Mr. deBortoli sent a letter of authorization to Mr. Priestly:

This letter is to confirm that Priestly Demolition is authorized to be on the property know [sic] as 151 Ontario Avenue to facilitate in the ongoing operations to extract victims from the collapsed portion of the Algo Centre Mall.

It is recognized that Priestly Demolition will not be responsible for the relocation of any material relocated from its present location on the site.<sup>388</sup>

Mr. Priestly testified that he requested this authorization from the City to ensure he had the official go-ahead to work on the Mall.<sup>389</sup>

## Mr. Hefkey is sent to Elliot Lake to assist with communications

On June 26, Mr. Hefkey was dispatched to Elliot Lake. Mr. McGuinty testified that the crisis warranted Mr. Hefkey's presence on the ground. Among many things, he could help with communications and be the person who gave regular updates to the media about the rescue operation, from both a municipal and a provincial perspective.<sup>390</sup>

## 8:15 a.m. – Mr. Hefkey visits Penguin Solutions and informs Staff Insp. Neadles about its equipment

En route to Elliot Lake, Mr. Hefkey stopped at 8:15 a.m. at Penguin Solutions, a mining equipment company in Sudbury, to observe a piece of equipment that had been suggested for use by the responders – a remotely operated vehicle that looked like a big Tonka truck and was equipped with sound detection, audio, cameras, and other equipment. It was made to operate in a mining environment. Penguin agreed to deploy the piece of equipment. Mr. Hefkey also met Rick Bartolucci, the minister of northern development and mines, at Penguin Solutions and then drove with him to Elliot Lake.<sup>391</sup>

As he was driving to Elliot Lake, at 9:48 a.m., Mr. Hefkey had a conversation with Staff Insp. Needles in which he informed him of the Penguin Solutions equipment offer. He advised him to take the opportunity to use it, although he recognized that, as the lead for the operations, the decision was for Staff Insp. Needles to make.<sup>392</sup>

### **10:21 a.m. – Mr. Hefkey arrives in Elliot Lake and goes immediately to meet the mayor**

At 10:21 a.m., when they arrived in Elliot Lake, Mr. Hefkey and Mr. Bartolucci met with Mayor Hamilton and Mr. deBortoli, the chief administrative officer. They expressed their condolences to both of these civic leaders and to the community. They told them they appreciated the tremendous pressures they were under and offered their support. Mr. Hefkey said he knew they were constantly in and out of meetings and, in order not to interrupt their work, he assured them that he and Mr. Bartolucci would be contacting the provincial resources, including HUSAR/TF3. He also told them that they would connect with the families.<sup>393</sup>

Mr. Hefkey explained that his role in Elliot Lake was to be the provincial spokesperson. He also met with family members of the victims who were being assisted by the OPP's provincial liaison team. He anticipated the raw emotions that the fiancé, the parents, and the children of the victims would express. When they complained about their frustration in not "hearing anything," he assured them that he would keep them informed of developments. They wanted to know that there was indeed a plan. Mr. Hefkey committed that, as events proceeded, he would tell the families what stage they were at in the plan. He also committed to sharing information and developments with them before the news was communicated publicly. Mr. Hefkey testified that, at that stage, the community knew there was one fatality, but it was not known whether there was another potential survivor or a second deceased person.<sup>394</sup>

Over the following two or three days, Mr. Hefkey testified that his role as the provincial spokesperson evolved. He had a conversation about future communications with Mayor Hamilton, Mr. Bartolucci, Insp. Percy Jollymore (the OPP detachment commander for the East Algoma Region), and Patrice Cloutier (a member of Mr. Hefkey's Communications Branch). He told them that he was offering his support to the community, recognizing that social media had a strong presence during an emergency event. He offered to share his resources to help them manage the flow of emergency information and its communication. During the meeting, Mayor Hamilton and Mr. deBortoli agreed that Mr. Hefkey could communicate with the media on matters of provincial interest. Mr. Hefkey wanted to respect the rules of engagement they had established with the Community Control Group. For that reason, he did not communicate any information about the victims – a responsibility that fell within the purview of the municipality.<sup>395</sup>

### **8:10 a.m. – Mr. Selvers becomes aware of the engagement of Priestly Demolition**

At 8:10 a.m., after speaking with Chief Officer, Dave Selvers, the president of Millennium Crane, learned that Priestly Demolition would be used on the site. He was familiar with the company, a prominent industry player that he had worked for on various occasions in steel mills. According to Mr. Selvers, it was a demolition and dismantling company.<sup>396</sup> In his testimony, he described his reaction to this news as being "like the air was let out of me."<sup>397</sup> If the rescuers were walking away from a rescue, he thought, they must have determined that no one was alive.<sup>398</sup> He explained that he understood the difference between a rescue and a recovery operation and that he was stunned when he learned that Priestly was coming. Priestly was involved in demolition activities, unlike Millennium Crane, which he felt is more surgical in its operations.<sup>399</sup>



Mr. Selvers recorded the following notes on this issue:

Further to this it must be understood that the proper method of approach initially implemented by the O.P.P. and Millennium Crane Rental was the only way to extricate "LIFE" ... the excavators with shears are only needed when all hope of life is lost. There is more agitation of structure with demolition as opposed to the precise and delicate motion of a crane. Given the fact that all hope of life had disappeared (according to the agency that put a halt to the rescue) it was only logical that a demolition of the structure commence to recover the deceased.<sup>400</sup>

He testified that Millennium Crane was there with the intention of removing survivors, and once the excavators were ordered in, its work was over.<sup>401</sup> Mr. Selvers testified that the agency he referred to as having put a halt to the rescue was the MOL.<sup>402</sup>

### **9:00 a.m. – the Collins Hall is reopened**

On June 26, at 9:00 a.m., the Collins Hall was opened again. However, Robin Kerr, the executive director of Victim Services for Algoma, felt that the time had come to change the services they offered and to transition from immediate crisis support services (offered by Victim Services) to longer-term services (offered by East Algoma Counselling Centre, East Algoma Mental Health, and Algoma Family Services). The hall therefore became more of an information centre where individuals could speak to counsellors and set up appointments.<sup>403</sup> It was open all day.

Insp. Jollymore informed Ms. Kerr that victim liaison officers from the OPP would be working with the victims' families and would not be going to the Collins Hall. She was therefore advised that she could open the Hall to the general public.<sup>404</sup> Ms. Kerr testified that Mrs. Perizzolo's daughter, her son-in-law Mr. Latulippe, and the parents and fiancé of Lucie Aylwin were well looked after by the victim liaison officers. She expressed the view, with which I agree, that these officers should have been brought in to assist the victims' families days earlier.<sup>405</sup>

Mr. Latulippe testified that, between 11:00 a.m. and 1 p.m. on June 26, the Community Services unit from the OPP tended to their needs and provided them with a place to stay at the offices of Edward Jones Investment, located close to the Mall but away from the media.<sup>406</sup> They also provided the families with information on how the operation would continue and ensured that two or three officers were with them at all times.<sup>407</sup>

### **Return of UCRT to the scene: on standby**

#### **9:00 a.m.–10:00 a.m. – UCRT team is advised that half the team will go home because the operation is now a recovery**

At approximately 9:00 a.m. or 10:00 a.m. on June 26, the UCRT team was briefed by Sgt. Gillespie in Massey. He advised them that the operation was now a recovery and that they would be keeping only six UCRT members to assist in that phase. Cst. Ryan Cox, a canine handler with the OPP, testified that he specifically recalled Sgt. Gillespie using the words "recovery operation." Sgt. Gillespie did not inform them why they had come to the conclusion that no live victims were left inside the collapse. Sgt. Gillespie advised Constables Cox and Bailey that they would be returning to do a cadaver search with their dogs. In his testimony, Cst. Bailey explained the sentiment felt by the UCRT members:

All of the [UCRT] guys wanted to stay. I mean, there wasn't one guy that wanted to leave but we were basically told that the numbers weren't required ... that they wouldn't be able to utilize all those people so that some guys would have to go home. I mean, it was at the point where guys were willing to draw straws because they didn't want to go home.<sup>408</sup>

Constables Patrick Waddick, Paul Webber, Steve Hulsman, Patrick Châtelain, Bailey, and Cox, along with one paramedic, remained on site.\*

### UCRT observes wrongly positioned shoring

Cst. Hulsman testified that the UCRT team was told that some heavy equipment was en route to Elliot Lake. On his arrival at the scene, he noted the numerous laced-post boxes that had been built by the HUSAR/TF3 team. The shores appeared properly constructed, but not properly positioned, because the weight was not directly over the vertical members. He explained:

Specifically when you look at the placement of the shore, you can see that the pieces running north to south, we refer to these 4X4 pieces as "headers," so there are two headers on either side of the laced-shore box, there is one on the west side that runs north to south and there is one on the east side that runs north to south. Those headers you can see have been butted up against the I-beam that holds the concrete floors above.

... according to our field operation guide, it doesn't follow the shoring principle, based on the fact that that one member – meaning the I-beam [ – ] has been placed in the middle of these headers. The structural strength of the laced-shore box happens when the weight is transferred from these header pieces and they come down the vertical 4X4 posts that you can see situated on each of the four corners.

If this was to break, instead of being as a total system, 32,000 pounds strong, you are now reducing that to just the sheer breaking strength of the two header pieces, and forgive me, I don't know the exact sheer breaking strength of a 4X4. I know it's going to be within the area of 500 pounds to 1,000 pounds.

...

If we were to shore up this I-beam, a better piece of shoring would have been either a 2-post, 3-post or 4-post vertical shores. And what I'm referring to is instead of having the headers that I referred to earlier, running perpendicular to the beam, the headers on the post, 3-post, 4-post vertical shores would run ... parallel.<sup>409</sup>

Cst. Hulsman testified that they were assigned to stand at a point of duty, observe the building from a safe distance, and report any movement.<sup>410</sup>

Cmdr. McCallion testified that he asked Sgt. Gillespie to assist in the construction of the shores. Sgt. Gillespie questioned why they were building the shores and was told they were to protect the veranda, or the balcony.<sup>411</sup>

### 10:50 a.m. – Sgt. Gillespie is advised by Staff Insp. Neadles

At approximately, 10:50 a.m., Sgt. Gillespie received a brief call from Staff Insp. Neadles requesting that UCRT have sufficient resources, canine and otherwise, to remove the victims from the rubble pile. Sgt. Gillespie received a similar request from Mr. Ellen, from the Fire Marshal's office. He was told there would be a six-person team for each extraction (regardless of how many extractions would be required), and the team would comprise two UCRT members, two HUSAR/TF3 members, and two Elliot Lake firefighters. Staff Insp. Neadles informed Sgt. Gillespie that they were required to be at the site by 2:00 p.m. These calls were not the first time Sgt. Gillespie had heard about the change of plans. At some point the night before, while they were on public order duty, it became apparent that discussions had taken place at high levels and that a plan was being prepared to demolish the front part of the building with the help of the Priestly machines. He gleaned this information during his work on the line and from the crowd. He was not advised by anybody in the chain of command.<sup>412</sup>

.....

\* Exhibit 6378, p. 031; this information was also confirmed by Sgt. Gillespie in an email he sent to Staff Sgt. Jacklin at 1:14 p.m. (Exhibit 9190, p. 005).

The operation was portrayed in the phone calls to Sgt. Gillespie as a rescue, but he was specifically asked to have both set of dogs (live and cadaver) attend, which rendered the situation somewhat confusing. Although Sgt. Gillespie's notes make reference to a recovery after the building demolition was complete, his use of this language was probably based on his previous experience, and not necessarily on what he was told at the time. His recollection was that he was told it was still a rescue, and that they were going to continue on that path.<sup>413</sup>

Sgt. Gillespie believed that the request for two Elliot Lake firefighters as part of the recovery team was due to the fact that they had all been working together as a group and, moreover, it was their community. The firefighters had not, however, been working on the pile, attempting to access the victims, and were not trained in structural collapse. Sgt. Gillespie testified that he thought the arrangements appeared more like an honour guard for recovery than a team for rescue.<sup>414</sup>

The operation was portrayed in the phone calls to Sgt. Gillespie as a rescue, but he was specifically asked to have both set of dogs (live and cadaver) attend, which rendered the situation somewhat confusing.

As far as Sgt. Gillespie was aware, there was no plan other than using the Priestly forces to reach the victims. He could not see any plan that would be viable other than demolishing the building. He testified that if the building could not be stabilized through shoring, demolition was the only way to avoid the danger of collapse.<sup>415</sup>

The UCRT team, particularly Constables Bailey and Cox as the canine handlers, remained on standby from 10:00 a.m. until 9:00 p.m.<sup>416</sup>

## Morning, June 26 – The Premier's Office is informed of the Priestly plan

### 9:14 a.m.–9:28 a.m. – Mr. O'Leary gathers information on latest steps and is advised that the military is on standby

Early on the morning of Tuesday, June 26, Mr. O'Leary gathered information with which to brief officials.<sup>417</sup> At 9:14 a.m., Ms. Miller sent an email to Mr. O'Leary, Mr. Hammond, and Ms. McCann with the subject line "PMSH authorizes Canadian forces – can you confirm?" She wrote:

Please note that Harper's Dcomm tweeted:

...

@pmharper spoke w Premier McGuinty last night – we've outlined fed and CAF capabilities and are waiting to hear as to what would be useful.<sup>418</sup>

Mr. O'Leary responded at 9:28 a.m.:

Confirmed. Our emergency officials have been in touch with the Canadian military. They have outlined what they could have that could be useful, whatever logistical or operational support may be deemed necessary. They are standing by now. Emergency officials at the scene will determine what if any military assets can be useful. We are engaged with the military to support the operation, and can confirm they have pledged full support.<sup>419</sup>

Mr. O'Leary testified that, ultimately, the emergency responders and those leading the rescue operations determined that they would not need assistance from the Canadian military.<sup>420</sup>



### 10:00 a.m. – The Premier’s Office is informed of Plan B

Later that morning, Mr. O’Leary took part in a telephone conversation with Deputy Minister Davidson (MCSCS), Ms. Conrad, and Carole Ritchie, who worked in Mr. Davidson’s office. The purpose of the call was to enable Mr. Davidson to provide further information on the developments and the operation under way.<sup>421</sup> Mr. O’Leary recorded the following note from the conversation:

ID – 3 large pieces of equip – b/w 12=2pm

- Will take 2 hrs to get set up
- Mining engineer not responded, but wanted to consult, get him there, ensure we can demonstrate to the mining community
- Greg Baden, world robotics leader, has equipment mine rescue & search – can use I needed
- Deployed by noon today
- OFM working on plans, determine once materials get there
- Dan on scene, less than 2 hrs
- Military – anything needed
- See what is avail
- Don’t have equipment we need
- Operation: pull away the walls, looking at scenarios based on equipment
- Will lift out escalator, remove the materials

Deconstruct scene

Vale stand ready to fully assist

- Expert here
- Full

OPP: sending up stress ppl, inc. XXX

- ERT – crowd control
- Energy team

Bill Neadles” operational commander

- OPP has Command Centre, used to communicate and co-ord on scene decon
- Being called a “rescue operation”<sup>422</sup>

Mr. O’Leary testified that Mr. Davidson informed them that three large pieces of equipment were being deployed and were due to arrive in Elliot Lake between noon and 2:00 p.m. that day.<sup>423</sup> It would take two hours for the equipment to be set up. A mining engineer had not responded to the scene in Elliot Lake but was available for consultation and to attend at the site, if needed. Mr. Davidson also spoke of Greg Baden, a world robotics leader, who had equipment that was used in mining search and rescue. The province would be able to use it if needed. He also indicated that the fire marshal was working on plans and would determine the next steps on the deployment of these assets. He stated that Mr. Hefkey had been on the scene for less than two hours. He also explained that the military had offered to supply anything that was needed, but it was unlikely it had the specific equipment that would be needed.<sup>424</sup>

During the call, Mr. Davidson provided a clearer understanding of the precise nature of the forthcoming operation. He described it as pulling away the walls. Ultimately, the escalator would be lifted out, the other materials and debris removed, and the scene deconstructed.<sup>425</sup> Vale, a mining company, was on standby and ready to assist. The OPP was deploying stress counselors, and had also sent an emergency response team (ERT) to perform crowd control.<sup>426</sup>

Mr. Davidson confirmed that Staff Insp. Neadles would be the operational commander of this operation and that the OPP had set up a command centre that would be used to communicate and coordinate on-the-scene decision making. Mr. Davidson also stated that the operation would be described as a rescue.<sup>427</sup> Mr. O'Leary testified that he thought Mr. Davidson was describing to him the activities that were currently taking place, which were appropriately called a rescue operation. He understood this term to mean that they were attempting to rescue anyone who might still be alive in the debris. Finally, Mr. Davidson advised Mr. O'Leary that the offices that were involved in coordinating provincial assets included the OPP, the Office of the Fire Marshal, and Emergency Management Ontario.<sup>428</sup>

Following his conversation with Mr. Davidson, Mr. O'Leary briefed the premier.<sup>429</sup>

### **11:51 a.m. – Mr. O'Leary believes that Mr. Hefkey should participate in the Community Control Group meetings**

At 11:51 a.m., Mr. O'Leary sent an email to Ms. Miller and Ms. McCann summarizing what he understood the situation to be at the time:

Brief update from officials.

Priestly is sending one large crane with 150ft reach from Toronto, a base for the crane from Aurora, a "shear" to cut through steel and a grappler, both from Sudbury. All are in transit, arriving by approx. 12 noon, and into service by 2pm.

Vale: has 2 engineers in Sudbury, their best and brightest, a mining and civil engineer. They are liaising with the HQ in Elliot Lake. I've told Cabinet Office that if there is any benefit to them being in EL in person, to get them in a car.

Manitoba has a HUSAR team similar to Toronto's, and they are standing by to attend to the scene. I have asked who needs to make the decision to activate them.

One robot from Sudbury is en route to EL, last update was it would be on scene by 12 noon.

Military: I have asked for Ian Davidson's advice on requesting someone from the military attend the scene. The emergency leaders there may not require military assistance, but in the even [*sic*] they do, I believe it could be beneficial to having the armed forces in the community already to coordinate on the ground. If there is even a slim benefit to the rescue to having someone from the armed forces at the HQ, I have asked that be pursued.

Intel on scene says the Mayor is extremely pleased by the efforts.

One thing to note: Dan Hefkey has been excluded from the community's control group, the team working with Bill Neadles to lead the operation. He is being briefed and kept in the loop, but is not present when the control group meets. I have requested Ian Davidson consider what can be done about that, if there is a benefit to having him in the group (my sense is, there IS). It may be something that the Premier and Mayor need to speak about but will get advice from Davidson.

Obviously a priority is the operational activity and the rescue itself, but I am concerned there has been no communication from the emergency team to the community today, and it is now midday. I have asked Davidson to advise on this, to see what he can do to help speed up a communications plan on the scene. Lack of communication in a crisis can make a bad situation worse, and we need them to turn their minds to how the public and people of EL are being kept informed. I have no confirmation on when a press conference will be taking place.<sup>430</sup>

Mr. O'Leary testified that he believed it would be a benefit for Mr. Hefkey, as the commissioner for community safety, to be participating in the CCG meetings. As one of the most senior officials in the province with respect to emergency management and operations, he might have expertise or knowledge that would prove to be useful.<sup>431</sup>

### 12:25 p.m. – The premier speaks to the mayor, who is desperate for communications support

At approximately 12:25 p.m., the premier arranged a phone call with the mayor. In the course of the conversation, Mayor Hamilton told him that he was desperate for communications support on the ground. Mr. McGuinty testified that the mayor seemed to be struggling to manage the huge number of media requests along with his other responsibilities.<sup>432</sup> He therefore asked the mayor if it would be appropriate for him to contact the families directly: He “was concerned about what was happening in the community, given the roller coaster ride they had just been through” as they were told the rescue was off, and then informed it was on again. His first concern, he said, was for the family members. The mayor agreed that the premier should contact the families.<sup>433</sup>

Premier McGuinty therefore spoke to the Aylwin and the Perizzolo families. He expressed his support, offered encouragement, and advised them that the rescuers had found another way to restart the rescue operation. He told them that Ontarians were thinking of them and held them in their thoughts and prayers.<sup>434</sup>

### Afternoon – Mr. O’Leary travels to Elliot Lake to provide communications support and become the premier’s eyes and ears on the ground

As a result of the mayor’s request for assistance on communications, the premier sent Mr. O’Leary to Elliot Lake to provide communications support. In addition, he wanted him there to ensure that he had a better sense of exactly what was happening and how things were unfolding on the ground.<sup>435</sup>

Mr. O’Leary explained that he saw his role in Elliot Lake in three different ways: to assist with communications; to be the eyes and ears of the premier and the Premier’s Office – to transmit information to them in real time and ensure that the information was flowing clearly; and to assist those leading the operation with obtaining provincial assets and to escalate requests, if necessary.

Mr. O’Leary was happy to go on the scene to assist, given the serious nature of the incident and the premier’s involvement.<sup>436</sup> He explained that he saw his role in Elliot Lake in three different ways: to assist with communications; to be the eyes and ears of the premier and the Premier’s Office – to transmit information to them in real time and ensure that the information was flowing clearly; and to assist those leading the operation with obtaining provincial assets and to escalate requests, if necessary.<sup>437</sup>

Later that day, Mr. O’Leary travelled to Elliot Lake with Jonathan Leigh from the Cabinet Office. They arrived on the evening of June 26 and returned to Toronto in the late afternoon of June 28. Mr. O’Leary believed he had done what he was supposed to do in Elliot Lake.<sup>438</sup>

### 11:00 a.m. – Community Control Group meeting: The City is informed of Plan B

#### Staff Insp. Needles outlines how the operation will unfold

At 11:00 a.m., the CCG met again. Staff Insp. Needles and Cmdr. McCallion were present.<sup>439</sup> Staff Insp. Needles advised the attendees, as per the notes of the meeting:

- Plan worked out w MOL is in motion.
- Worked with engineers – approved by Dan Hefky [sic]
- Estimate: quarter of a million
- Priestly Demolition contacted for demo equipment. HUGE.
- Take an arm over roof use claw to take escalators and push it (fault it) in a controlled way away from victims.



- Under order of MOL—site visit.
- This morn authorized—escalator is still moving / shifting.
- Wait for results of push.
- Secondary controlled collaps. [sic]
- Move machine out bring in grapples, eliminate piece by piece making victims accessible.
- Will them seek guidance of MOL engineer to enter bld. Will bring in a K9 search team. Search & cadaver dogs.
- Contact coroner for authorization to remove the bodies<sup>440</sup>

Staff Insp. Needles testified that the site preparation was being done by a local contractor, and that the team on the ground was working on the shoring and the removal of the pneumatic shores in the north end.<sup>441</sup>

Referring to the note “worked with engineers,” Staff Insp. Needles did not know who the other engineer was, aside from Mr. Jeffreys. He stated that he did not refer to anyone other than Mr. Jeffreys.<sup>442</sup> He testified that the estimated price came from Sgt. Glavin. The final tally was about \$300,000. He did not sign off on the amount.<sup>443</sup>

Staff Insp. Needles initially testified he not did believe they were under any MOL order. He testified that he may have said it but he did not know what it referred to. He later modified his evidence, claiming that he was under the belief that the MOL had issued an order that required Capt. Comella to get permission from the ministry before going inside to check the device for more movement of the building.<sup>444</sup>

Staff Insp. Needles then explained to the group that the workers would push the slabs and the escalator away from where they believed the victims to be, with primary consideration being given to where the live victim was thought to be located. He warned them that this attempt might result in a collapse. Subsequently, they would move the bigger Priestly machine out of the way and bring the smaller one with grapples inside to remove the debris piece by piece. In that way they hoped to be able to access the victims.<sup>445</sup>

As I explain below, the initial plan had to be modified to allow for the removal of the front of the Mall because the Priestly high-reach crane was not able to get into the building from above. The rest of the operation proceeded in a methodical fashion from the south end of the building, moving north to reach first Mrs. Perizzolo and then Ms. Aylwin.<sup>446</sup>

Staff Insp. Needles testified that he expected that a reassessment of the area and the building would be conducted by the MOL engineer and that his advice would be sought about allowing the team to re-enter the building. The comment in his notes did not relate to any action to be taken by the MOL as an authority.<sup>447</sup>

With respect to his comment, “Contact coroner for authorization to remove the bodies,” Staff Insp. Needles confirmed that this statement was consistent with what he believed was a definite recovery for one individual and a probable recovery for the other.<sup>448</sup>

### **Mr. Jeffreys claims he was not yet consulted**

Mr. Jeffreys, who was not at the meeting, testified that, contrary to the indication in the notes, he did not recall discussing a plan other than speaking to Capt. Comella about having to go through the front of the building. Mr. Jeffreys testified that, at this point, he did not even know what equipment was coming or its capability. He was therefore not part of any plan.<sup>449</sup> However, he confirmed that he did assist later with a rescue / recovery procedure plan, as I describe below.<sup>450</sup>

In addition, Mr. Jeffreys testified that he did not know what was meant by the notes “Under order of MOL – site visit this morn authorized – escalator is still moving / shifting.” He again confirmed that the order issued on June 26 to prevent access to the Mall specifically exempted rescue and recovery workers.<sup>451</sup>

### **Chief Officer understands the risk of Plan B**

Chief Officer testified that the equipment was supposed to be tall enough and have a long enough reach to push the escalator down and keep it away from the pile.<sup>452</sup> This operation was to be done without inside access. He also explained that the risks with this procedure were that, once demolition of the building began, it would be very hard to predict how the structure would come down. They would lose control over the debris, which might fall onto the victims.<sup>453</sup>

### **During the day of June 26 – Frustration increases again among the community**

Mr. Mantha observed that, by Tuesday morning, people in town were getting frustrated again because it took some time for the large Priestly crane to arrive. Then they started seeing some road modifications in order to accommodate the crane. Once the crane was on site, it needed to be assembled, which required more time. The community wanted to see an end to the operation. By the time the demolition actually started, a large group of people was on the street, watching it happen. Mr. Mantha believed the crane operations started that evening and that most of them were completed on June 27.<sup>454</sup>

### **Between 11:00 a.m. and the arrival of the Priestly equipment – firefighters assist with logistics**

Chief Officer testified that he and his men took care of the logistics between the time Plan B was shared by Staff Insp. Neadles at the 11:00 a.m. CCG meeting and the actual recoveries of the victims, which took place on June 27. They brought in material to build the platform for the equipment, raised hydro lines, and redirected the road that entered the south end of the Mall so that the turn would not be too steep for the large trucks carrying the cranes.<sup>455</sup> They also had to move the command tent and other equipment out of the way.<sup>456</sup>

### **12:35 p.m. – Staff Insp. Neadles provides the Office of the Fire Marshal with an update: The equipment is en route and a press conference is planned for 1:00 p.m.**

At 12:35 p.m., Staff Insp. Neadles sent his second email update of the day to members of the HUSAR/TF3 team as well as the Office of the Fire Marshal:

As of noon ... A control group meeting took place at 1100 hours. At this time I outlined the Operational plan that was approved by Dan Hefkey last night.

All heavy equipment is enroute and will be escorted by either TPS/OPP or both.

The work has commenced on the excavation of the site to allow easy access for all the Tractor Trailers of Heavy equipment on the site.

There will be a Press Conference at 1300 hours to lay out the plan moving forward.

The Teams are continuing shoring the side of the mall to add stability of the structure upon the controlled secondary collapse of the escalator.

Thanks to all for the support to the team members from our home Agencies to their respective members.<sup>457</sup>

I note again that while Mr. Hefkey might have been under the impression that his approval was not needed for the recovery plan, it is clear that in Staff Insp. Neadles's mind, approval had been granted. Staff Insp. Neadles believed that he had the support of senior provincial officials.

## 1:00 p.m. – Press conference: Staff Insp. Neadles advises the public of Plan B

At the 1:00 p.m. press conference, Staff Insp. Neadles stated the following:

[A]s was indicated when we were stood down from yesterday, when we were not allowed to enter the building ... we had no *[sic]* given up our efforts to come up with a plan to move forward. As I tried to indicate yesterday, *our authority did end when the building was deemed unsafe by the ministry and other structural engineers*, but when the commitment by the mayor was given to you, that was also something I ... wasn't able to give to you, but I was on the same page with the mayor. And then with the enhanced authority given to me by Mr. Hefkey through the province of Ontario to then set the next plan in motion, I think you are going to see some very serious machinery roll into town in the next couple of hours to assist us, to further advance our operation to move into that building as safely as we can. How we plan to do that I am going to try and show you as simply as I can because I will tell you it had to be shown to me simply because I'm not ... a heavy equipment expert. We've enlisted ... the services of Priestly, who are a major construction firm in the greater Toronto area to bring a brand new, multi-million dollar piece of equipment ...<sup>458</sup> [Emphasis added.]

Staff Insp. Neadles testified that he believed his authority ended when he pulled the team out of the building. He explained that he was using the expression "authority" as meaning that he did not have the authority to go forward because he did not have the capability. He also admitted that, when he pulled his team from the pile, he did not have any idea what to do or have any plan in place. He confirmed that there was no document (legal or otherwise) describing his authority and that his mandate was to attempt to rescue people from the collapsed buildings as best as he could.<sup>459</sup>

Regarding his comment "enhanced authority," Staff Insp. Neadles testified that he did not have the financial authority to approve Priestly but was assured by Mr. Hefkey that the company would be retained.<sup>460</sup>

Staff Insp. Neadles went on to describe the plan to the attendees of the press conference:

Our intention from there is, because of the proximity of the victims to that escalator, and I'll ... speak to that in a minute as well, we will do a controlled dismantling of that escalator. We will push it with this machine backwards which should cause it ... to fall. And then, but it will be a controlled maneuver and will fall away from the victims on the floor. Once that settles and then we see how things do move on that maneuver, we'll take a step back to have the engineers re-assess and then we will start to ... move in from the front of the building to start sheering off ... the south-east corner there. We will start to sheer the front doors, the entire way will be cleared by ... this heavy equipment very gingerly, as these guys are professionals. They know exactly how to do what they do as quickly as it can be done. Once that avenue is ... cut through the building the victims are approximately 35, 40 feet from that door, we'll then continue to clean a pathway with these pieces of equipment that, again, based on a very clear pathway and approval from the Ministry of Labour's structural engineer and others who are assisting him in advice, if that is deemed safe for our people to enter, we will then approach and deal with both victims that are in there ... [W]hen we get there, we will deal with them accordingly. I think that ... the main action plan, as I would call it, *[is]* to start. I will advise that when Mr. Priestly, who owns the company, it's a four generation, family-owned business and one of the Priestly sons are coming with this machine to operate it, when Mr. Priestly arrives, we have dealt with this company in the past. We find them to be one of the ... best ones there. We will send him along with one member of my team, who is an engineer and the structural engineer of the Ministry of Labour to do a final assessment.<sup>461</sup>



Staff Insp. Neadles testified that the operation consisted of a controlled and precise removal of the debris, as opposed to going directly to the area where they believed the victims were located.<sup>462</sup> When asked why he did not go directly to the victims, Staff Insp. Neadles stated that they had been provided with an estimate of six to eight hours to complete the operation.<sup>463</sup> He believed he had a conversation with Capt. Comella about the possibility of getting to the victims more quickly, but it was the tactical decision of Capt. Comella and Mr. Jeffreys on the ground to proceed the way they did. However, according to Staff Insp. Neadles, as soon as the mechanical portion of the operation had been completed and the reassessment made to ensure it was safe, the rescuers were sent on the pile.<sup>464</sup>

Staff Insp. Neadles testified that the “one member of my team” referred to in his statement at the press conference – that he “will ... send him ... along with one member of my team, who is an engineer and the structural engineer of the Ministry of Labour” – was Capt. Comella, even though he was not an engineer. He explained that he was probably referring to them as an engineering group, although he acknowledged that what he said was specific.<sup>465</sup>

In a later address to the public at the press conference, Staff Insp. Neadles stated: “One further task that we will perform is once the *engineer has allowed* us to enter the building, if and when that happens, I will order a canine search” [emphasis added].<sup>466</sup> Staff Insp. Neadles confirmed that the engineer he was referring to was Mr. Jeffreys, who was giving them advice. He explained that he used the word “allowed” not in the sense that Mr. Jeffreys had the power to prevent them from entering the building, but in the sense of him providing advice, as a certified engineer, on whether it was prudent for them to enter.<sup>467</sup>

During the press conference, Staff Insp. Neadles was also asked whether HUSAR/TF3 had ever saved anyone from a real building collapse and whether he personally had experience in actually rescuing someone from a collapsed building, other than in training and in competitions.<sup>468</sup> He responded to the second part of the question by referring to the Bloor Street explosion in 2003. When asked about the first part of the question, he testified that HUSAR/TF3 had never actually saved anybody from a building collapse – whether like this one or otherwise.<sup>469</sup> However, he also testified that this collapse was the only deployment in which he was involved where there was the possibility of survivors when his team arrived.<sup>470</sup>

I find Staff Insp. Neadles’s comments during the press conference somewhat disingenuous. By suggesting that they had never given up, he was clearly attempting to revisit the comments he had made the day before when he announced he was putting an end to the rescue. As I describe previously, it is clear in my view that the rescue had stopped. Further, it appears to me that the characterization of this next step of the response as a “rescue” was not accurate. It became apparent from the responders’ subsequent actions that it had become a recovery.

### 3:00 p.m. – Mr. Selvers is released

At 1:00 p.m., Mr. Selvers was told to “pack-up” by Staff Insp. Neadles. Mr. Selvers explained to him that because he had been hired by the OPP to assist with the collapse, he was under its care and direction and could be released only by that agency.<sup>471</sup>

Mr. Selvers told Sgt. Gillespie that he had been rudely ordered by HUSAR/TF3 to leave the site. Sgt. Gillespie thought that Millennium Crane’s services had been invaluable. However, because Priestly was on its way, he understood that Millennium’s services might no longer be required. He wanted to confirm this point. He therefore spoke to Mr. Ellen, who happened to be near that location. Mr. Ellen confirmed that the Millennium crane was no longer required.<sup>472</sup>

Sgt. Gillespie then encountered Cmdr. McCallion, who “barked an order” at him to get rid of the crane operator because he had told him to leave two hours earlier. He said he wanted Mr. Selvers “out *now*.” Sgt. Gillespie went

over and spoke to Mr. Selvers. Again Mr. Selvers said, given that he had been hired by the OPP, he would not leave unless the OPP advised him he was no longer required. He also wanted to confirm for certain that they no longer needed his services because of the time it takes to rebuild a crane once it has been taken apart. Sgt. Gillespie confirmed that the crane would no longer be used in the rescue effort.<sup>473</sup>

At 3:00 p.m.,\* Cst. Waddick advised Mr. Selvers to pack up. At that point, Mr. Selvers knew that his mission was over.<sup>474</sup> Before he left the site, Sgt. Gillespie signed his job book and work tickets.<sup>475</sup>

### **3:05 p.m. – Staff Insp. Neadles advises Mr. Hefkey that he thinks they are in a recovery situation; Mr. Hefkey later holds a media scrum to outline the next steps**

At 3:05 p.m., Mr. Hefkey met with Staff Insp. Neadles, who laid out the plan on how they were going to use the heavy equipment when it arrived. In his notes, Mr. Hefkey recorded the following comment from Staff Insp. Neadles: “He does think we are in a recovery situation but will still hold out and hope and will proceed as a rescue.”<sup>476</sup> Staff Insp. Neadles testified that he was hopeful that the operation would be a rescue, but, realistically, he was looking at it as a recovery.<sup>477</sup>

At 4:30 p.m., Mr. Hefkey held a media scrum. He explained the estimated time of arrival of the Priestly equipment and how it would be used. He also provided some answers with respect to this new plan and the intervention of the premier.<sup>478</sup>

### **Plan B is executed: Priestly demolishes part of the Mall**

#### **4:00 p.m. – Mr. Priestly meets with HUSAR/TF3 and the Ministry of Labour and conducts a reconnaissance of the site**

At 4:00 p.m., Mr. Priestly arrived on the scene and met with Sgt. Glavin, who introduced him to Staff Insp. Neadles and his crew, including Capt. Comella. Mr. Priestly testified that Mr. Jeffreys was also present and was helpful in giving the background of what had transpired and the issues moving forward. He explained to Mr. Priestly the structural issues with the building and why it had collapsed.<sup>479</sup> Mr. Priestly testified that on his arrival on the site, he sensed the urgency of the situation. His team did not stop working until the next morning.<sup>480</sup>

Mr. Priestly did a reconnaissance of the site along with Mr. Jeffreys. He believed that the MOL had shut down access to the site completely to protect the safety of the workers, but he was not sure. Mr. Priestly explained that during his walk through the site, he observed that the beam supporting the loads of the escalator and the core slabs was “very” bent. In his opinion, it was only a matter of time before it failed.<sup>481</sup> He was told where the possible victims were thought to be: one by the pay phones, and the other victim’s location marked with a pylon.<sup>†</sup> He believed that no one knew whether any victim was alive or dead, though “there was a glimmer of hope.”<sup>482</sup> Mr. Priestly focused on his job – to take down the building in order to gain access.<sup>483</sup> He was operating under the assumption that the victims were still alive. Mr. Priestly testified that Capt. Comella wanted to make sure that nothing fell on the victims during the operation.<sup>484</sup>

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\* There is some discrepancy with respect to the time that Mr. Selvers was advised to leave. Sgt. Gillespie in his notes indicates that it was at 6:30 pm (Exhibit 6378, p. 032), while Mr. Selvers indicates that it was at 3:00 p.m. Although I do not believe anything turns on the time, I am inclined to agree with the timing of Mr. Selvers, given that Mr. Priestly testified that Millennium Crane had left the site by the time he and his team arrived. Mr. Priestly arrived on the site at 4:00 p.m. Priestly testimony, October 2, 2013, p. 27863.

† Capt. Comella confirmed this description during his testimony. Comella testimony, September 5, 2013, pp. 24363–4.

### Shortly after 4:00 pm – Mr. Priestly and others draft a “rescue / recovery” plan

Following the reconnaissance of the site, Mr. Priestly thought it would be best to spend some time planning and determining the direction of the operation while waiting for the equipment to arrive and be assembled.<sup>485</sup> He met with Mr. Sanders, Don Jewitt (a MOL manager from Thunder Bay), Capt. Comella, and Mr. Jeffreys. They discussed safety and engineering concerns.<sup>486</sup>

Mr. Jeffreys testified that Capt. Comella asked him to give some advice on putting the plan together, from an engineering perspective.<sup>487</sup> Mr. Priestly testified that Mr. Jeffreys provided engineering advice during the formulation of the plan, including stoppage if necessary. They wanted to proceed safely and did not want anyone else to get hurt.<sup>488</sup>

Capt. Comella testified that they felt it was important to try to articulate a plan. They were worried about the rest of the building collapsing when the operation began. They wanted Priestly to reach around the top of the escalator resting on the beam (with core slabs resting on top of it) and pull the escalator back toward the south so that it stayed off the pile. It was hoped that it would fall away from the pile and be removed.<sup>489</sup>

Mr. Jeffreys understood that Mr. Priestly wanted something documented before proceeding.<sup>490</sup> Mr. Priestly explained that under the Ontario *Building Code*, a written demolition plan, stamped by an engineer, was required for the demolition of a building over 6,000 square feet or three storeys in height.<sup>491</sup> Mr. Jeffreys believed that it was an excellent idea to write down what the plan was, what was going to be done, what safety measures were going to be taken, and who would stand where.<sup>492</sup>

A plan, entitled “Rescue / Recovery Procedure Plan,” was eventually drafted and signed by Mr. Priestly, Mr. Jeffreys, and Staff Insp. Neadles.\* Mr. Priestly could not remember whether he had a role in giving the plan this title. He testified that he would have proceeded in the same manner whether it had been considered a rescue or a recovery.<sup>493</sup>

Mr. Jeffreys, however, in his notes referred to the fact that he was asked to assist with a plan to make the “recovery” safe. He testified that he referred to it as a recovery because, at the 3 p.m. meeting the previous day, he had thought that the operation had moved from a rescue to a recovery. He did not recall any discussion that the mission was back to a rescue despite the fact that the HUSAR/TF3 team was moving forward.<sup>494</sup>

According to Mr. Jeffreys, his signature on the document was not an indication that he approved the plan. He signed the document because it was the plan the group put together and represented what had been agreed to.<sup>495</sup> He felt the difference between agreeing to something and approving something was that approval was akin to an official stamp.<sup>496</sup> Nonetheless, Mr. Jeffreys testified that the team could have gone ahead without his signature. None of the parties made his signature a prerequisite to the implementation of the plan.<sup>497</sup>

Staff Insp. Neadles confirmed that this document was the first written plan of the entire operation.<sup>498</sup>

The plan consisted of seven elements:

- “Confirm all services including gas, water, electricity etc. are shut off prior to any operation taking place.”<sup>499</sup> Mr. Priestly testified that he wanted this standard item in the plan to ensure that he did not cut a hydro or a gas line.<sup>500</sup>

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\* Priestly testimony, October 2, 2013, pp. 27849–50; Exhibit 7296; Neadles testimony, September 12, 2013, pp. 25631–2 (according to the scribe’s notes, it appears that Staff Insp. Neadles signed off on the plan at 9:05 p.m.).



- “Confirm COLD ZONE is in place ...”<sup>501</sup> Mr. Priestly explained that he wanted to make sure that nobody would enter the zone while they were working on the building. It is also a requirement of the *Occupational Health and Safety Act* that when a building is being torn down, it be secured.<sup>502</sup>
- “Move the Komatsu PC850 [high-reach machine] with UP20 attachment onto new stone pad adjacent to the building and check compaction using the Komatsu PC850.”<sup>503</sup> Mr. Priestly explained that the high-reaching machine was very heavy, and he therefore wanted to run the machine back and forth a few times on the pad to make sure it was well compacted before extending the boom up and over the building.<sup>504</sup>
- “Place spotter on roof in safe location with MOL and HUSAR escort.”<sup>505</sup> Mr. Priestly testified that the spotter was a member of his team whose role was to direct Mr. Priestly in operating the Komatsu 850 – from his position in the machine, he could not see into the building.<sup>506</sup>
- “Reach Komatsu PC850 with UP20 attachment over penthouse and into collapse zone to check for position of UP20 in close proximity to concrete slab(s) resting on beam at north end of escalator with NO contact.”<sup>507</sup> Mr. Priestly explained that he wanted to make a dry run to see if they would be able to reach the area where the slabs were sitting on the escalators.<sup>508</sup> The dry run would involve reaching over with the arm and trying to get as close as possible to this slab.<sup>509</sup>
- “Spotter with MOL and HUSAR escort to evacuate from roof area to COLD ZONE prior to ANY contact with concrete slab(s) resting on beam at north end of escalator.”<sup>510</sup>
- “ALL CLEAR radio command from Tony Comella followed by go-ahead to apply pressure with UP20 onto concrete slab(s) resting on beam at north end of escalator.”<sup>511</sup> Mr. Priestly testified that the purpose of this step was to have a controlled drop of those slabs early on so they did not fall on the victims. He explained that the beam was bent in such a bad way that it looked as though, if they applied pressure on it, it would fail in a controlled manner and drop down to the floor.<sup>512</sup> The slabs would then be on the floor and the victims would be out of harm’s way.<sup>513</sup> He explained that he could ensure that the beam would fall in a controlled way because the machine can be operated precisely, so it could reach over, cut the beam, and slowly lower it.<sup>514</sup>

In his testimony, Mr. Priestly confirmed that the plan did not work because the machine could not reach the beam.<sup>515</sup> It was about 20 feet from the beam, and the main boom was within inches of touching the penthouse. Pointing to the photograph in figure 2.6.5, Mr. Priestly testified that the Komatsu 850 was positioned in the same place as the yellow truck in the upper right corner of the image.<sup>516</sup>



**Figure 2.6.5** The position of the Komatsu when it attempted to move the beam

Source Exhibit 2114

The plan went on to state:

DECISION A) If beam failure occurred – assessment to be completed by HUSAR / MOL / PRIESTLY

Next steps are to “Nibble” building from top down and out to the angle of repose on both sides, exposing collapse zone with no overhead items over collapse zone.

DECISION B) If beam does not fail – assessment to be completed by HUSAR / MOL / PRIESTLY

Next steps are to remove penthouse and “Nibble” building from top down and out to the angle of repose on both sides exposing collapse zone with no overhead items over collapse zone.<sup>517</sup>

Referring to Plan A above, Mr. Priestly testified that if the beam collapsed, meaning that it and the slabs were resting on the ground, the next step would be to take the rest of the building down so they could get in there with the heavy equipment.<sup>518</sup> He explained that if that happened, the primary risk to the rescuers would have been taken care of to a certain degree. However, it had been decided that the responders would re-evaluate the situation when they reached that point.<sup>519</sup> Mr. Priestly was asked if the beam and the slabs had collapsed why the next step would not be an attempt to access a possible live victim. The primary hazard, after all, would have been removed. He testified that that was the intention as soon as the victims could be accessed safely.<sup>520</sup> When asked how nibbling at the building from the top down out to the angle of repose would contribute to accessing the victim safely, Mr. Priestly testified that the slabs and the escalators would have created a very big pile of debris on the ground (not where the victims were believed to be), which had to be removed for the victims to be reached.<sup>521</sup> Rescuers would have to move around that debris, or walk over it or around it, to access the victims. Although it might have been possible to access the pile from a different direction, Mr. Priestly said that this possibility had been exhausted even before he and his team arrived. The key issue was that the victims were not accessible.<sup>522</sup>

Mr. Priestly testified that his equipment could not have continued the type of rigging operation conducted by Millennium – to take slabs directly out of the pile after the escalator had been taken down – because it did not have the necessary reach.<sup>523</sup> He explained that, after the danger presented by the escalator and the slabs had been removed by collapsing them, he believed Millennium could not have continued the slinging operation because the pile of debris was tangled and rigging would have been difficult. The slabs would have had to be cut in order to be rigged safely. They were not stacked neatly and there were pipes between them. He believed that rigging would have been more difficult than using the excavators to lift the slabs out, which is what was done in the end. Mr. Priestly could not remember whether any rescue leaders asked him if he had the capacity to resume that rigging operation.<sup>524</sup>

Mr. Priestly testified that he believed at the time that it would take between six and eight hours to “nibble” the building down from top to bottom and out to the angle of repose on both sides. He stated that it was a guaranteed process, given the cracked and broken state of the slabs.<sup>525</sup> He believed the safest way to proceed was to take down the part that had collapsed and to make a “nice” pathway in, so the responders could get through and delicately remove the slabs in such a way that there would be no further pressure on the victims.<sup>526</sup>

Staff Insp. Needles admitted that this document was not only the first written plan associated with this operation but the first with a Plan B.

### **6:00 p.m. – The Priestly high-reach machine arrives on site: The first attempt does not work**

The CCG met at 5 p.m., and Staff Insp. Needles informed the group that Mr. Priestly was on site and happy with the layout. He advised the group that it would take approximately 1.5 hours to take down the escalator and six to eight hours to “open up” the building.<sup>527</sup>

At 6:00 p.m., Priestly's high-reach machine arrived and work began on its assembly.<sup>528</sup> Mr. Priestly testified that the assembly took approximately two hours. They then performed a dry run that did not work because they could not reach the beam inside the Mall. They moved to Plan B, as outlined in the "Rescue / Recovery Procedure Plan".<sup>529</sup>

DECISION B) If beam does not fail—assessment to be completed by HUSAR/MOL/PRIESTLY

Next steps are to remove penthouse and "Nibble" building from top down and out to the angle of repose on both sides exposing collapse zone with no overhead items over collapse zone.<sup>530</sup>

Mr. Priestly agreed that Plan A and Plan B were similar except for the fact that, in the first scenario, the beam had been caused to fail (collapse), whereas in the second it had not. The purpose of causing the beam to fail in Plan A was to ensure that nothing further fell on the victims.<sup>531</sup> Because the escalator and the slab were on an angle aiming down toward where the victims were located, the workers were hoping to eliminate the risk of anything sliding down on them. Plan B provided that they would take part of the building down, so it would be safe to go in and access the victims. Mr. Priestly testified that they would prevent anything from sliding down toward the victims in Plan B by performing the demolition in a very controlled manner and by not working too quickly or causing any unplanned structural failures. They intended to cut down the penthouse in a sequential manner to lighten the load as they progressed.<sup>532</sup>

Mr. Priestly testified that it would have been too dangerous to attempt to secure the slabs on the escalator by tying them back (to prevent the accidental sliding of the slab). Furthermore, no one was allowed to go inside the zone.<sup>533</sup>

### **6:58 p.m. – Staff Insp. Needles sends update to the Office of the Fire Marshal: The high-reach machine has arrived**

At 6:58 p.m., Staff Insp. Needles sent an email update to members of the HUSAR/TF3 team as well as the Office of the Fire Marshal:

Press conference went well with the focus again ... on the delay and work stoppage.

The excavation of the site has been ongoing and almost complete to receive the Articulating Arm Machine.

The Articulating Arm has just arrived and is being assembled. It will take 1–2 hours.

The 1800 Control Group meeting has started to focus on the post recovery period when the Ministry of Labour Orders take effect.

As soon as the equipment is ready to operate it will be deployed immediately.

It will take approx 2 hours to deal with the Escalator.

Team members doing well. 1 minor injury (sprained ankle) last night.

Next Control Group meeting TBD.

Next update: when important info to pass along.<sup>534</sup>

Staff Insp. Needles confirmed that the "post recovery period when the Ministry of Labour Orders take effect" referred to the fact that the MOL would take control of the structure.<sup>535</sup>



### 9:00 p.m. – Demolition of the Mall takes place in a controlled manner

At 9:00 p.m., the demolition began.<sup>536</sup> At the same time, a UCRT team briefing was held for the six remaining members. The team was advised that the demolition of the building would begin with the use of a specialized crane excavator to start removing the south portion of the Mall. The team in charge of the demolition was requesting the presence of various observers with radios around the perimeter as the equipment removed steel, aluminum, and various objects. As the operation was taking place, they wanted individuals to be looking for any indications of damage or structural issues to the building and to report any such concerns. The UCRT team was provided with HUSAR/TF3 radios to use for this communication. Constables Bailey and Cox were part of the team that conducted the assessment around the perimeter. They were observing from the south / east area of the parking lot.<sup>537</sup>



**Figure 2.6.6 The Komatsu 850 removing the windows of the penthouse**

Source Exhibits 9580 and 9897

### The Mall is demolished

Mr. Priestly described the demolition that ensued as follows:

- The first step of Plan B was to deal with the penthouse and start “nibbling” down from the top. Figure 2.6.6 illustrates the Komatsu 850 removing the windows of the penthouse and taking down the architectural feature.<sup>538</sup>
- Mr. Priestly testified that he operated the Komatsu 850 and that there was no spotter during the actual operation, as there had been for the dry run.<sup>539</sup>
- The architectural feature of the penthouse was eventually removed and the ceiling of the penthouse became visible.<sup>540</sup>
- After taking down the penthouse, Mr. Priestly testified they took down the entire exterior walkway at the second level of the Mall. It was necessary to remove the walkway in order to extend the machine’s reach into the building. Once accomplished, they could get into the collapsed zone with the Link Belt 460 and cut the beams.<sup>541</sup>

- When the walkway was removed, using the Link Belt 460 (having backed the Komatsu 850 out of the way), they took down the beam (having first removed all the precast slabs) that joined the exterior walkway and the third floor.<sup>542</sup> They ensured that the beam would not come crashing down by cutting it on an angle, so it would sit on the stub that was left. They then placed the shear underneath the beam, closed it, cut the beam, and lowered that section down slowly.<sup>543</sup>
- The second beam that was removed from the third level was the beam supporting the escalator.<sup>544</sup> All that was left was the steel frame with the escalator, because the doors, windows, roof, and walls had all been pushed to the parking lot. The precast slabs weighed about four or five tons each, so every time they took down a piece of precast slab, it had to be moved out of the way.<sup>545</sup> Mr. Priestly testified that the beam bore approximately half the weight of the escalator, but he was not worried that the cutting process would add extra weight and cause the beam to fall – it was a stronger beam than the one at the exterior.<sup>546</sup> Mr. Priestly was able to cut the beam at an angle at one end and then cut the second end the other way. The escalator weighed about 10 tons, but he succeeded in lowering it gently and resting it on the floor below.<sup>547</sup> Mr. Priestly testified that the core slab that was lying on the escalator was lowered with it.<sup>548</sup> He then tried to remove it with the Link Belt 460. He did not have the spotters on the roof when he performed this part of the operation.<sup>549</sup>



**Figure 2.6.7 The penthouse is demolished**

Source Exhibit 9898



**Figure 2.6.8 The Link Belt 460 removing the escalators and the overlying concrete slabs**

Source Exhibit 9901



- While Mr. Priestly agreed that although the core slabs overlying the escalator appeared to be in a precarious position, he did not believe that any part of the debris lying on the slab fell onto the pile below. He explained that once the escalator was torn down and everything was out of the way, there was no evidence of new debris on the pile. He stated that not even one of the masonry blocks fell onto the pile.<sup>550</sup> He acknowledged, however, that he did not take comparison pictures of the pile before and after the operation and that there were no spotters to confirm his description of the scene.<sup>551</sup>
- The next step was to repeat the same process, moving down to the lower level.<sup>552</sup> He took out the second floor beams and the escalator that went from the ground floor to the second floor, and he removed the debris in that area so the responders could get to the pile where the victims were located.<sup>553</sup> When he had access to the compromised beam, he cut the escalator before cutting the beam.<sup>554</sup> At that point, the beam had little or no load on it. Mr. Priestly testified that the beam was bent “a lot.” He believes it was 18 to 24 inches lower than its intended position. He said he was surprised that the beam did not fail, given all the work that had occurred so close to it. He removed the beam with the shear of the Link Belt 460, by cutting one end first, then the other end, and finally taking it down carefully. At that point, the rescuers had clear access to the pile.<sup>555</sup>
- The next step of the operation was to rake all the material out, down to the concrete floor, with the excavator with the grapple – the Komatsu 490. To do so, he used a large steel beam in a motion similar to sweeping the floor with a broom. Figure 2.6.9 illustrates the result of the sweeping.<sup>556</sup>



**Figure 2.6.9 The Mall interior after the Komatsu 490 cleared out the debris**

Source: Exhibit 7924

Mr. Priestly testified that once he got to this point in the operation, he took very detailed instructions from Capt. Comella, who he described as the point man in charge. He then started pulling back some debris very gently and began to lift off some of the slabs.<sup>557</sup> Every time he pulled back or lifted some debris, the responders would check for any kind of evidence. Mr. Priestly testified that he believed they found a woman's handbag.<sup>558</sup>

### **Observations from responders: The demolition was conducted in a satisfactory manner**

Capt. Comella was on site during the demolition. He testified that he observed some of it, but also spent a lot of time walking around. He was not sure if he saw the escalator come out. He

certainly saw debris. He saw the Priestly team working at it as well as the end result, but he did not watch the whole operation.<sup>559</sup>

Capt. Comella testified that after the demolition was over, the pylon that had been used to mark the location of a possible victim was still where it had been positioned. They were satisfied with the crane operation and thought it had been successful in pulling the debris back toward the south end of the Mall. They did not think the crane affected the pile where the victims were located.<sup>560</sup>



Mr. Jeffreys watched the Priestly operation and thought it was more effective than rigging with a crane. Slinging material was a slower process because it took time to rig the slabs so they would not slip out while they were being lifted. The Priestly machine, in contrast, was faster – it could simply reach in, pick up a slab, and move it aside. He also observed that the Priestly operation was safer because it allowed for removal of portions of the building in order to get up closer without exposing workers, whereas to sling, workers had to be in close to the demolition.<sup>561</sup>

Mr. Jeffreys described the greater versatility of the Priestly machine as follows:

The Priestly equipment is far more versatile. It can crush pieces. It can pick up pieces. It can snip off huge pieces of steel, as if they were paper and very meticulously.<sup>562</sup>

He also described Priestly's surgical precision:

Absolute surgical precision on Mr. Priestly's part ... when he ... had brought the front of the building down, the victims were recovered. He then took a piece of steel that was about 10 feet long and used it like a spatula, to bring all the debris out. You can't do any of those things with a crane.<sup>563</sup>

Cst. Cox noted that this demolition was controlled.<sup>564</sup> Based on what he observed, he determined it was a recovery at that point. He did not observe anything that would cause him concern with respect to the victims. He testified that if somebody was still alive in the rubble, he did not see anything that could potentially have caused further injury to that person. He admitted, however, that he was not observing when the Priestly team brought the escalator down and did not see how they ensured that the concrete that was resting on the escalator did not slide forward onto the pile where the signs of life had been found.<sup>565</sup>

Cst. Cox testified that he did not know who was in charge at that point, Priestly or HUSAR/TF3. He saw that the HUSAR/TF3 members were in the same holding pattern as the UCRT members. UCRT and HUSAR/TF3 were on standby until Priestly finished doing its controlled demolition. No rigging was being done at that point.<sup>566</sup>

### **June 27, 3:00 a.m. – Cadaver search conducted with UCRT dogs**

At 2:55 a.m., Sgt. Gillespie received a call from Capt. Comella asking him to prepare the UCRT cadaver dogs for a search on the pile. He woke up Constables Cox and Bailey and advised them to prepare their dogs.<sup>567</sup> At 3:05 a.m., he received the same request from Staff Insp. Needles.<sup>568</sup>

### **Cst. Bailey is concerned about the dogs' safety and about contamination of the scent by HUSAR/TF3 members**

Constables Bailey and Cox followed instructions and prepared the dogs.<sup>569</sup> Cst. Bailey then approached Sgt. Gillespie and told him that HUSAR/TF3 members were also on site with other dogs, thereby contaminating the area with human scent. In this regard, Sgt. Gillespie noted:

Bailey ... indicated to me that TF3 is now putting HUSAR dog ... and that they have put several people (TF3 members) contaminating the area with scent. He asked about is this a rescue or is this a recovery. They indicated rescue. Advised PC Bailey to document his conversation and return to his assigned task.<sup>570</sup>

Cst. Bailey informed Sgt. Gillespie that he did not feel that what they were requesting of him was safe. He had been asked to take his cadaver dog and "throw him up onto the top of the escalator," which at the time was still in the Mall. Cst. Bailey was concerned because, in training sessions, they do not throw their dogs up into the air. Moreover, because a lot of broken glass had fallen directly on top of the escalator and the stairwell, the surface was unsafe for the dog. He then asked Staff Insp. Needles whether the operation was a rescue or a recovery at

that point: the level of risk he would allow the dog to take would depend on the type of operation. He explained that in a rescue you may sometimes take some risks (such as having your dog get hurt). In a recovery, however, you can “slow down” and make some changes to ensure that the dog does not get hurt. It appears from his notes that Cst. Bailey was informed that this operation was still a rescue and that they were searching for a live victim. He nonetheless suggested dragging the escalator shaft into the parking lot to have it at ground level, and then lifting the dog up 5 feet to get to the top of the escalator.\*

Sgt. Gillespie also advised Staff Insp. Needles of Cst. Bailey’s concern with respect to contamination of the scene. He documented their conversation as follows:

Approached Bill Needles in an off side bar conversation.

[Gillespie] “Bill I am sure you are aware of the conversation my handler just had with your members about the K9 search and the scent issue”

[Needles] “I’m aware of some of it”

[Gillespie] “He explained to me that the area is being contaminated by human scent and your dog as well as the cadaver scent that we know the location of. They train with distraction and multiple scents but with all of this contamination they need to conduct the search without all of your guys in the area. Them being there is making things quite difficult.”

[Needles] “ok”

Sgt. Gillespie continued as follows:

Very distressed that we are telling them how to run the search. Apparent they (CTF3) are acting as this is still a rescue operation even though this is statistically impossible and they (Needles [sic]) has only asked for cadaver dogs from OPP.<sup>571</sup>

Sgt. Gillespie testified that he was getting mixed messages: “[I]t was a rescue but we want cadaver dogs.” He further explained that it seemed that the focus was on a recovery and it “didn’t make sense.” According to him, they were being too precise, methodical, and slow – steps they would not have taken in the context of a rescue.<sup>572</sup>

### **A search is performed on the escalator by Cst. Cox with the cadaver dog Fuse: There is no indication of any victims**

As I describe above, Priestly did eventually drag the escalator out of the Mall. Cst. Cox testified that he was asked to go to the south entrance of the Mall for further instructions on the canine search to be conducted. When he arrived, a discussion ensued as to how the dogs were going to search the area. His dog Fuse was not trained to work off-leash. Because this operation was a recovery, he did not feel it was safe for his dog to search the pile, given the way the debris was spread out. Therefore, they made the decision to pull the escalator further out into the parking lot so that Fuse could search the stairs and the escalator, specifically, for any evidence of victims. Fuse searched the escalator and provided no indication.<sup>573</sup>

.....

\* Bailey testimony, August 27, 2013, pp. 22790–2; Bailey testimony, August 28, 2013, pp. 22866–7. The search being conducted was not in the actual pile in the Mall where the victims were located, but in a pile of debris that had been dragged outside the Mall.

### **HUSAR/TF3 members bring their dog to search the escalator; UCRT members question again whether the operation is a rescue or a recovery**

When Fuse completed his search, Cst. Cox observed a live search dog belonging to the HUSAR/TF3 team standing at the south entrance of the Mall with his handler (Sgt. Scott Fowlds), Capt. Comella, and another HUSAR/TF3 member. The dog went a few feet into the pile (outside the Mall) and came back to his handler. Sgt. Fowlds testified that his dog Ranger gave no indication and showed no interest in the escalator.<sup>574</sup> The handler was having a conversation with Capt. Comella. Constables Bailey and Cox approached Capt. Comella and asked him whether this operation was a rescue or a recovery. They were told it was still a rescue and that they were searching for a live victim. In his notes, Cst. Cox questioned why a cadaver dog was used first if the operation was still a rescue.<sup>575</sup>

Cst. Bailey told the HUSAR/TF3 members that he would not perform a search with a cadaver dog until the operation officially became a recovery. He documented his frustration about the fact that the operation seemed to be alternating between a rescue and a recovery.<sup>576</sup> He testified: "It's kind of like we're here, we're there. It's we'll try this, we'll try that. Well ... if this doesn't work, let's try this." He was told that it was still a rescue, and that it would switch to a recovery only if the HUSAR/TF3 dogs failed to indicate a live human in the debris.<sup>577</sup>

### **8:00 p.m. – Mr. Lacroix advises Sgt. Gillespie that the MOL did not shut down the rescue**

At 8:00 p.m., Sgt. Gillespie had a conversation with Michael Lacroix, an inspector with the Ministry of Labour, with respect to the decision to stop the rescue. Sgt. Gillespie testified that it never really made sense to him that the MOL had stopped the work because of the overloading of the beam. He understood that the ministry was involved, given that two of the three engineers on site were from the MOL, but not that MOL made the decision to stop the work.<sup>578</sup> He made the following note of the conversation:

Met with Michel Lacroix (mol) and Dave Howse (ofm). Asked Lacroix – 'this is bothering me that the decision to stop work: Who made that decision'.

[Lacroix] – "Don (MOL) made an order for stop work once the engineers completed calculations and stated 468% overload and assessed the building. That order does not apply to rescue operations."

[Lacroix] – "We did not stop the rescue. That decision was made at an Incident Command meeting. Not by us."

[Gillespie] "I was told by them (TF3 McCallion) that the MOL stopped any work and that no one is allowed inside"

[Lacroix] – "Not by us. It was stopped by the command committee."

[Gillespie] – "I was lied to about this. They complained to me about OUR actions during the crane ops and that we had too many people on the pile and that we endangered their rescue crews."

[Lacroix] – "We didn't have any issue with what you guys were doing. I did not know that they had any issues with that operation."<sup>579</sup>

Sgt. Gillespie felt that he had been lied to and that the information he had been provided simply "didn't make sense."<sup>580</sup>



Mr. Lacroix testified that during his conversation with Sgt. Gillespie, he was adamant that the MOL did not stop the rescue operation. He told him that the MOL had not put a stop-work order on the rescue operations. He was surprised that Sgt. Gillespie thought the MOL had shut down the rescue. He recalled at some point discussing the perception that the MOL had shut down the rescue with Mr. Jones, Mr. Jeffreys, or Mr. Sanders. He was not aware if they took any steps to correct that perception. Mr. Lacroix testified that he had “no idea” why that perception existed.<sup>581</sup>

## **Conclusion: Responders were operating as though this operation was a recovery**

A review of the conduct of the responders at the time, along with the fact that Plan B resulted in the use of a demolition company, leads me to conclude that all involved were operating, perhaps subconsciously, as though this operation was a recovery mission.

## **Evening – Premier McGuinty does not want to be a distraction to the operation**

By Tuesday evening, the premier was aware that the rescue was moving forward with the assistance of the Priestly equipment. He also had dispatched to Elliot Lake two very senior government officials to assist with the management of the incident. When asked whether he thought he should be travelling to Elliot Lake himself at that point, Mr. McGuinty testified that he felt it was still premature for him to go to the community. He did not want to be a distraction to the work that was ongoing. He believed he was able to assist from Toronto, through his office, without impeding the operation in any way.<sup>582</sup>

## **June 27, 6:00 a.m. – Demolition is completed by Priestly**

According to Mr. Priestly’s notes, the demolition was completed by 6:00 a.m. on June 27. He testified that he considered the demolition to have been completed around the time when all the escalators were removed and the ground floor had been cleaned to the point where it was safe to walk in and look above without worrying that anything would come down.<sup>583</sup>

Mr. Priestly testified that he cleared the sides of the building where there were overhanging pieces that appeared likely to fall. Figure 2.6.10 shows Mr. Priestly clearing out the collapsed zone.<sup>584</sup>

While he was clearing out, Mr. Priestly explained that tin studs may have fallen onto the pile, but that, generally, most of the debris stayed together with the machine as he did the work. He also explained that a couple of small pieces of concrete from the slabs on the parking level fell while he was clearing out the area, but they were in a corner where they did not think a victim was located (see fig. 2.6.11, right side).<sup>585</sup>



**Figure 2.6.10** Mr. Priestly at work removing debris from the collapsed zone in the Mall

Source Exhibit 9904



**Figure 2.6.11** The corner where some small pieces of concrete may have fallen during the clearing of the Mall

Source Exhibit 7924

## Notes

- <sup>1</sup> McGuinty testimony, October 9, 2013, pp. 28983–6.
- <sup>2</sup> McGuinty testimony, October 9, 2013, pp. 28876–7.
- <sup>3</sup> O'Leary testimony, September 17, 2013, pp. 25829–31.
- <sup>4</sup> O'Leary testimony, September 17, 2013, p. 25873.
- <sup>5</sup> Mantha testimony, September 23, 2013, pp. 26730–3.
- <sup>6</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>7</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>8</sup> O'Leary testimony, September 17, 2012, pp. 25831–3.
- <sup>9</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>10</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>11</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>12</sup> McGuinty testimony, October 9, 2013, pp. 28877–81.
- <sup>13</sup> O'Leary testimony, September 17, pp. 25835–7.
- <sup>14</sup> Exhibit 8115.
- <sup>15</sup> O'Leary testimony, September 17, p. 25834.
- <sup>16</sup> Exhibit 8116.
- <sup>17</sup> Exhibit 8117.
- <sup>18</sup> Exhibit 8119.
- <sup>19</sup> O'Leary testimony, September 17, 2013, pp. 25834–9.
- <sup>20</sup> O'Leary testimony, September 17, 2013, pp. 25840–2.
- <sup>21</sup> Exhibit 8121; O'Leary testimony, September 17, 2013, pp. 25843–4.
- <sup>22</sup> Exhibits 8119 and 8121.
- <sup>23</sup> Exhibit 8125.
- <sup>24</sup> Exhibit 8121.
- <sup>25</sup> O'Leary testimony, September 17, 2013, pp. 25843–7; McGuinty testimony, October 9, 2013, pp. 28881–6.
- <sup>26</sup> Exhibit 8125; O'Leary testimony, September 17, 2013, pp. 25844–6.
- <sup>27</sup> Exhibit 8125; O'Leary testimony, September 17, 2013, pp. 25486–7.
- <sup>28</sup> McGuinty testimony, October 9, 2013, p. 28882.
- <sup>29</sup> McGuinty testimony, October 9, 2013, pp. 28885–6.
- <sup>30</sup> Exhibit 6348; O'Leary testimony, September 17, 2013, pp. 25848–9.
- <sup>31</sup> Exhibit 8128.
- <sup>32</sup> O'Leary testimony, September 17, 2013, pp. 25849–50.
- <sup>33</sup> O'Leary testimony, September 17, 2013, pp. 25849–50 and 25852.
- <sup>34</sup> Exhibit 8128.
- <sup>35</sup> Exhibit 8128; O'Leary testimony, September 17, 2013, p. 25852.
- <sup>36</sup> McGuinty testimony, October 9, 2013, pp. 28890–1.
- <sup>37</sup> O'Leary testimony, September 17, 2013, p. 25854.
- <sup>38</sup> Exhibit 8129.
- <sup>39</sup> Exhibit 8130.
- <sup>40</sup> O'Leary testimony, September 17, 2013, pp. 25853–4.
- <sup>41</sup> O'Leary testimony, September 17, 2013, pp. 25854–5.
- <sup>42</sup> Exhibit 8132.
- <sup>43</sup> O'Leary testimony, September 17, 2013, pp. 25855–6.
- <sup>44</sup> Exhibit 8126.
- <sup>45</sup> O'Leary testimony, September 17, 2013, pp. 25857–8.
- <sup>46</sup> Exhibit 8126.
- <sup>47</sup> O'Leary testimony, September 17, 2013, pp. 25858–9.
- <sup>48</sup> Exhibit 8134.
- <sup>49</sup> Exhibit 8135.
- <sup>50</sup> McGuinty testimony, October 9, 2013, pp. 28891–2.
- <sup>51</sup> Exhibit 8135.
- <sup>52</sup> McGuinty testimony, October 9, 2013, p. 28892.
- <sup>53</sup> Exhibit 8135; see also McGuinty testimony, October 9, 2013, pp. 28893–4.
- <sup>54</sup> Exhibits 8138 and 8146; O'Leary testimony, September 17, 2013, pp. 25861–2 and 25864–5.
- <sup>55</sup> Exhibit 8136; McGuinty testimony, October 9, 2013, pp. 28894–5.
- <sup>56</sup> McGuinty testimony, October 9, 2013, pp. 28895–7.
- <sup>57</sup> O'Leary testimony, September 17, 2013, p. 25863.
- <sup>58</sup> O'Leary testimony, September 17, 2013, pp. 25863–4.
- <sup>59</sup> O'Leary testimony, September 17, 2013, p. 25865.
- <sup>60</sup> Exhibit 8152.
- <sup>61</sup> McGuinty testimony, October 9, 2013, pp. 28897–900.
- <sup>62</sup> Exhibit 8162; McGuinty testimony, October 9, 2013, pp. 28900–2.
- <sup>63</sup> Exhibit 6639.
- <sup>64</sup> O'Leary testimony, September 17, 2013, pp. 25866–7.
- <sup>65</sup> O'Leary testimony, September 17, 2013, p. 25868.
- <sup>66</sup> Exhibit 6630.
- <sup>67</sup> McGuinty testimony, October 9, 2013, pp. 28902–3.
- <sup>68</sup> Exhibit 6632.
- <sup>69</sup> McGuinty testimony, October 9, 2013, pp. 28903–5.
- <sup>70</sup> McGuinty testimony, October 9, 2013, pp. 28905–6.
- <sup>71</sup> Exhibit 8205, p.038.
- <sup>72</sup> Exhibit 8196.
- <sup>73</sup> Exhibit 8205; Mantha testimony, September 23, 2013, pp. 26740–1.
- <sup>74</sup> Exhibit 8279.
- <sup>75</sup> Exhibit 8205.
- <sup>76</sup> O'Leary testimony, September 17, 2013, pp. 25869–70.
- <sup>77</sup> McGuinty testimony, October 9, 2013, pp. 28906–7.
- <sup>78</sup> McGuinty testimony, October 9, 2013, pp. 28907–8.
- <sup>79</sup> Exhibit 8196.
- <sup>80</sup> Exhibit 8196.
- <sup>81</sup> McGuinty testimony, October 9, 2013, pp. 28908–11.
- <sup>82</sup> Exhibit 8221.
- <sup>83</sup> Exhibit 8221.
- <sup>84</sup> McGuinty testimony, October 9, 2013, pp. 28908–11.
- <sup>85</sup> Mantha testimony, September 23, 2013, pp. 26741–4 and 26747–9; see also Exhibit 8267.
- <sup>86</sup> Mantha testimony, September 23, 2013, pp. 26745–7.
- <sup>87</sup> Exhibit 8196; O'Leary testimony, September 17, 2013, p. 25870.
- <sup>88</sup> O'Leary testimony, September 17, 2013, pp. 25870–1.
- <sup>89</sup> Exhibit 9140, pp. 1625–6.
- <sup>90</sup> O'Leary testimony, September 17, 2013, pp. 25876–8.
- <sup>91</sup> O'Leary testimony, September 17, 2013, pp. 25878–9.
- <sup>92</sup> O'Leary testimony, September 17, 2013, p. 25880.
- <sup>93</sup> O'Leary testimony, September 17, 2013, pp. 25880–1.
- <sup>94</sup> Hefkey testimony, October 8, 2013, pp. 28606–14.
- <sup>95</sup> Exhibit 8196.
- <sup>96</sup> O'Leary testimony, September 17, 2013, pp. 25871–2.
- <sup>97</sup> Exhibit 8267.
- <sup>98</sup> O'Leary testimony, September 17, 2013, pp. 25893–5.
- <sup>99</sup> McGuinty testimony, October 9, 2013, pp. 28912–14.
- <sup>100</sup> Exhibit 8223.
- <sup>101</sup> Exhibit 6378, p. 13; Exhibits 7828 and 7829; Gillespie testimony, September 3, 2013, p. 23626.
- <sup>102</sup> Exhibit 6378, p. 16; Gillespie testimony, September 3, 2014, pp. 23647–8.
- <sup>103</sup> Exhibit 8260.
- <sup>104</sup> Exhibit 8262.
- <sup>105</sup> Exhibits 8266 and 8267.



- <sup>106</sup> Exhibit 8266.
- <sup>107</sup> Mantha testimony, September 23, 2013, pp. 26748–9.
- <sup>108</sup> Exhibit 8267; O’Leary testimony, September 17, 2013, pp. 25891–3.
- <sup>109</sup> Mantha testimony, September 23, 2013, pp. 26749–51.
- <sup>110</sup> Mantha testimony, September 23, 2013, pp. 26751–4.
- <sup>111</sup> Mantha testimony, September 23, 2013, pp. 26754–5.
- <sup>112</sup> Mantha testimony, September 23, 2013, pp. 26798–99.
- <sup>113</sup> Exhibit 8270; O’Leary testimony, September 17, 2013, p. 25896.
- <sup>114</sup> Exhibit 8270.
- <sup>115</sup> O’Leary testimony, September 17, 2013, p. 25897.
- <sup>116</sup> Exhibits 8271 and 8272.
- <sup>117</sup> Exhibit 6961.
- <sup>118</sup> Exhibit 6962.
- <sup>119</sup> O’Leary testimony, September 17, 2013, pp. 25898–9.
- <sup>120</sup> McGuinty testimony, October 9, 2013, pp. 28914–17 and 28918–19.
- <sup>121</sup> McGuinty testimony, October 9, 2013, p. 28917.
- <sup>122</sup> Exhibit 9914.
- <sup>123</sup> Exhibit 8275.
- <sup>124</sup> Exhibit 8279.
- <sup>125</sup> O’Leary testimony, September 17, 2013, pp. 25899–900.
- <sup>126</sup> Exhibit 8281; O’Leary testimony, September 17, 2013, pp. 25900–1.
- <sup>127</sup> O’Leary testimony, May 13, 2013, p. 25901.
- <sup>128</sup> Exhibit 9140, p. 003; O’Leary testimony, September 17, 2013, pp. 25901–2.
- <sup>129</sup> O’Leary testimony, September 17, 2013, p. 25902.
- <sup>130</sup> O’Leary testimony, September 17, 2013, pp. 25903–5.
- <sup>131</sup> Exhibit 8282.
- <sup>132</sup> Exhibit 9140.
- <sup>133</sup> O’Leary testimony, September 17, 2013, pp. 25905–6.
- <sup>134</sup> O’Leary testimony, September 17, 2013, pp. 25906–10; Exhibit 9140.
- <sup>135</sup> O’Leary testimony, September 17, 2013, pp. 25908–9.
- <sup>136</sup> Exhibit 6964.
- <sup>137</sup> O’Leary testimony, September 17, 2013, pp. 25910–11.
- <sup>138</sup> Exhibit 9140; O’Leary testimony, September 17, 2013, pp. 25914–15.
- <sup>139</sup> O’Leary testimony, September 17, 2013, p. 25921.
- <sup>140</sup> O’Leary testimony, September 17, 2013, pp. 25921–3; Exhibit 6976.
- <sup>141</sup> Exhibit 6966; O’Leary testimony, September 17, 2013, pp. 25919–20.
- <sup>142</sup> Exhibit 6966; O’Leary testimony, September 17, 2013, pp. 25920–1.
- <sup>143</sup> O’Leary testimony, September 17, 2013, pp. 25915–17; Exhibit 9140.
- <sup>144</sup> Exhibit 9140, p. 004.
- <sup>145</sup> O’Leary testimony, September 17, 2013, pp. 25918–19; Exhibit 9140.
- <sup>146</sup> Exhibit 8297; O’Leary testimony, September 17, 2013, p. 25923.
- <sup>147</sup> Exhibit 8297; O’Leary testimony, September 17, 2013, pp. 25923–4.
- <sup>148</sup> Exhibits 6976 and 9648.
- <sup>149</sup> Exhibits 6976 and 9648; O’Leary testimony, September 17, 2013, pp. 25933–8.
- <sup>150</sup> Exhibit 8302.
- <sup>151</sup> O’Leary testimony, September 17, 2013, pp. 25924–6.
- <sup>152</sup> Exhibit 8303.
- <sup>153</sup> O’Leary testimony, September 17, 2013, pp. 25926–7.
- <sup>154</sup> Exhibit 8313; see also Exhibit 8312.
- <sup>155</sup> Exhibit 8313.
- <sup>156</sup> O’Leary testimony, September 17, 2013, pp. 25928–9.
- <sup>157</sup> O’Leary testimony, September 17, 2013, pp. 25932–3.
- <sup>158</sup> McGuinty testimony, October 9, 2013, pp. 28921–2.
- <sup>159</sup> McGuinty testimony, October 9, 2013, pp. 28922–3.
- <sup>160</sup> McGuinty testimony, October 9, 2013, pp. 28923–6.
- <sup>161</sup> Exhibit 6977.
- <sup>162</sup> O’Leary testimony, September 17, 2013, pp. 25938–40.
- <sup>163</sup> O’Leary testimony, September 17, 2013, p. 25940.
- <sup>164</sup> Exhibit 8318.
- <sup>165</sup> Exhibit 8296, p. 001.
- <sup>166</sup> Exhibit 8296, p. 001.
- <sup>167</sup> Exhibit 8296, p. 002.
- <sup>168</sup> O’Leary testimony, September 17, 2013, pp. 25943–4.
- <sup>169</sup> Exhibit 8296, p. 095.
- <sup>170</sup> O’Leary testimony, September 17, 2013, p. 25947.
- <sup>171</sup> Exhibit 9140, p. 0004.
- <sup>172</sup> O’Leary testimony, September 17, 2013, p. 25948.
- <sup>173</sup> O’Leary testimony, September 17, 2013, pp. 25948–9.
- <sup>174</sup> Exhibit 9140, p. 004; O’Leary testimony, September 17, 2013, p. 25950; McGuinty testimony, October 9, 2013, pp. 28927–8.
- <sup>175</sup> McGuinty testimony, October 9, 2013, pp. 28926–9; Exhibit 9140, p. 004.
- <sup>176</sup> McGuinty testimony, October 9, 2013, pp. 28945–6.
- <sup>177</sup> O’Leary testimony, September 17, 2013, p. 25950.
- <sup>178</sup> Exhibit 8324; O’Leary testimony, September 17, 2013, pp. 25951–2.
- <sup>179</sup> Exhibit 7812, p. 006.
- <sup>180</sup> Hefkey testimony, October 8, 2013, pp. 28626–9.
- <sup>181</sup> Needles testimony, September 11, 2013, p. 25517.
- <sup>182</sup> Needles testimony, September 11, 2013, pp. 25517–18.
- <sup>183</sup> Needles testimony, September 11, 2013, pp. 25518–19.
- <sup>184</sup> Needles testimony, September 11, 2013, pp. 25519 and 25522.
- <sup>185</sup> Needles testimony, September 11, 2013, pp. 25522–3.
- <sup>186</sup> Needles testimony, September 11, 2013, p. 25523.
- <sup>187</sup> Needles testimony, September 11, 2013, pp. 25519–20.
- <sup>188</sup> Needles testimony, September 11, 2013, p. 25520.
- <sup>189</sup> Needles testimony, September 11, 2013, p. 25521.
- <sup>190</sup> Needles testimony, September 11, 2013, p. 25524.
- <sup>191</sup> Hefkey testimony, October 8, 2013, pp. 28626–9.
- <sup>192</sup> Needles testimony, September 11, 2013, p. 25525.
- <sup>193</sup> Hefkey testimony, October 8, 2013, pp. 28626–9; Exhibit 7812, p. 006.
- <sup>194</sup> Glavin testimony, October 1, 2013, pp. 27726–30; Exhibits 7617 and 6622.
- <sup>195</sup> Glavin testimony, October 1, 2013, pp. 27730–2; Exhibits 7617 and 6622; Priestly testimony, October 2, 2013, pp. 27807–10 and 27813–14.
- <sup>196</sup> Priestly testimony, October 2, 2013, pp. 27815–16.
- <sup>197</sup> Glavin testimony, October 1, 2013, pp. 27732–3; Priestly testimony, October 2, 2013, pp. 27808–9 and 27812–14.
- <sup>198</sup> Glavin testimony, October 1, 2013, pp. 27733–5.
- <sup>199</sup> Exhibit 9140, pp. 004–006; Exhibit 7812, pp. 006–007; see also O’Leary testimony, September 17, 2013, pp. 25953–4; Hefkey testimony, October 8, 2013, pp. 28631–2.
- <sup>200</sup> O’Leary testimony, September 17, 2013, pp. 25953–4.
- <sup>201</sup> McGuinty testimony, October 9, 2013, p. 28932.
- <sup>202</sup> McGuinty testimony, October 9, 2013, p. 28931.

- <sup>203</sup> O'Leary testimony, September 17, 2013, p. 25952; Hefkey testimony, October 8, 2013, p. 28632; Exhibit 9140, pp. 004–006; Exhibit 7812, pp. 006–007.
- <sup>204</sup> Neadles testimony, September 11, 2013, p. 25528.
- <sup>205</sup> Neadles testimony, September 12, 2013, pp. 25548–9.
- <sup>206</sup> McGuinty testimony, October 9, 2013, p. 28932; Exhibit 9140, p. 004.
- <sup>207</sup> O'Leary testimony, September 17, 2013, pp. 25954–5; Neadles testimony, September 11, 2013, pp. 25529–30; Exhibit 9140, p. 005.
- <sup>208</sup> Exhibit 9140, p. 005.
- <sup>209</sup> Neadles testimony, September 11, 2013, pp. 25530–1.
- <sup>210</sup> Neadles testimony, September 11, 2013, pp. 25531–2.
- <sup>211</sup> McGuinty testimony, October 9, 2013, pp. 28933–4; O'Leary testimony, September 17, 2013, pp. 25955–7; Neadles testimony, September 11, 2013, pp. 25532–3; Exhibit 9140, p. 005.
- <sup>212</sup> McGuinty testimony, October 9, 2013, pp. 28933–4; O'Leary testimony, September 17, 2013, pp. 25955–7; Exhibit 9140, p. 005.
- <sup>213</sup> Exhibit 9140, p. 005; Exhibit 7812, p. 007; Hefkey testimony, October 8, 2013, pp. 28632–3.
- <sup>214</sup> O'Leary testimony, September 17, 2013, pp. 25956–7.
- <sup>215</sup> Neadles testimony, September 11, 2013, pp. 25512–13 and 25533.
- <sup>216</sup> Feldman testimony, September 18, 2013, pp. 26034–9.
- <sup>217</sup> Feldman testimony, September 18, 2013, pp. 26041–2.
- <sup>218</sup> McGuinty testimony, October 9, 2013, p. 28933.
- <sup>219</sup> Exhibit 9140, p. 005.
- <sup>220</sup> Neadles testimony, September 11, 2013, pp. 25533–4.
- <sup>221</sup> Neadles testimony, September 11, 2013, pp. 25533–5, September 12, 2013, p. 25559; Exhibit 7812, p. 007; see also Hefkey testimony, October 8, 2013, pp. 28633–4.
- <sup>222</sup> O'Leary testimony, September 17, 2013, p. 25957.
- <sup>223</sup> McGuinty testimony, October 9, 2013, p. 28934.
- <sup>224</sup> Exhibit 9140, p. 005.
- <sup>225</sup> Exhibit 7812, p. 007; Neadles testimony, September 12, 2013, pp. 25559–60; Hefkey testimony, October 8, 2013, pp. 28634–6.
- <sup>226</sup> McGuinty testimony, October 9, 2013, pp. 28935–6.
- <sup>227</sup> O'Leary testimony, September 17, 2013, p. 25958.
- <sup>228</sup> Neadles testimony, September 11, 2013, pp. 25555–7.
- <sup>229</sup> Neadles testimony, September 12, 2013, pp. 25560–1.
- <sup>230</sup> Exhibit 9140, p. 005.
- <sup>231</sup> McGuinty testimony, October 9, 2013, pp. 28936–8.
- <sup>232</sup> O'Leary testimony, September 17, 2013, pp. 25958–9; McGuinty testimony, October 9, 2013, pp. 28936–7.
- <sup>233</sup> McGuinty testimony, October 9, 2013, p. 28941.
- <sup>234</sup> O'Leary testimony, September 17, 2013, p. 25965.
- <sup>235</sup> O'Leary testimony, September 17, 2013, pp. 25964–5.
- <sup>236</sup> Exhibit 7812, p. 007; see also Hefkey testimony, October 8, 2013, pp. 28636–7.
- <sup>237</sup> Neadles testimony, September 12, 2013, pp. 25549–50.
- <sup>238</sup> Neadles testimony, September 12, 2013, p. 25561.
- <sup>239</sup> Neadles testimony, September 12, 2013, pp. 25561–2.
- <sup>240</sup> Exhibit 9140, p. 005; Exhibit 7812, p. 007; Neadles testimony, September 12, 2013, p. 25563; Hefkey testimony, October 8, 2013, pp. 28637–8.
- <sup>241</sup> McGuinty testimony, October 9, 2013, pp. 28938–9; see also O'Leary testimony, September 17, 2013, p. 25959.
- <sup>242</sup> McGuinty testimony, October 9, 2013, p. 28940; Exhibit 9140, pp. 005–006; see also Hefkey testimony, October 8, 2013, pp. 28638–40.
- <sup>243</sup> Neadles testimony, September 12, 2013, pp. 25550–1.
- <sup>244</sup> Neadles testimony, September 12, 2013, pp. 25551–3.
- <sup>245</sup> Neadles testimony, September 12, 2013, pp. 25563–4.
- <sup>246</sup> O'Leary testimony, September 17, 2013, p. 25960; Exhibit 9140, p. 006.
- <sup>247</sup> Exhibit 9140, p. 006; Neadles testimony, September 12, 2013, pp. 25553–4.
- <sup>248</sup> Exhibit 9140, p. 006; O'Leary testimony, September 17, 2013, p. 25960; Neadles testimony, September 12, 2013, p. 25564.
- <sup>249</sup> Exhibit 9140, p. 006.
- <sup>250</sup> Neadles testimony, September 12, 2013, p. 25556.
- <sup>251</sup> Neadles testimony, September 12, 2013, pp. 25556–7.
- <sup>252</sup> Neadles testimony, September 12, 2013, p. 25557.
- <sup>253</sup> Neadles testimony, September 12, 2013, pp. 25557–8.
- <sup>254</sup> O'Leary testimony, September 17, 2013, p. 25961.
- <sup>255</sup> McGuinty testimony, October 9, 2013, pp. 28941–2.
- <sup>256</sup> O'Leary testimony, September 17, 2013, p. 25961.
- <sup>257</sup> McGuinty testimony, October 9, 2013, pp. 28941–2.
- <sup>258</sup> McGuinty testimony, October 9, 2013, pp. 28942–4.
- <sup>259</sup> McGuinty testimony, October 9, 2013, p. 28946.
- <sup>260</sup> Neadles testimony, September 12, 2013, p. 25566.
- <sup>261</sup> Neadles testimony, September 12, 2013, pp. 25566–8.
- <sup>262</sup> Neadles testimony, September 12, 2013, p. 25565.
- <sup>263</sup> Neadles testimony, September 12, 2013, p. 25566.
- <sup>264</sup> Hefkey testimony, October 8, 2013, p. 28642.
- <sup>265</sup> Hefkey testimony, October 8, 2013, pp. 28641–2.
- <sup>266</sup> McGuinty testimony, October 9, 2013, pp. 28944–5; Mantha testimony, September 23, 2013, pp. 26774–80.
- <sup>267</sup> Mantha testimony, September 23, 2013, pp. 26774–80.
- <sup>268</sup> Mantha testimony, September 23, 2013, pp. 26774–80.
- <sup>269</sup> McGuinty testimony, October 9, 2013, pp. 28946–8.
- <sup>270</sup> McGuinty testimony, October 9, 2013, p. 28948; Exhibit 8346; O'Leary testimony, September 17, 2013, pp. 25962–3.
- <sup>271</sup> Exhibit 3743, pp. 040–041; Officer testimony, August 22, 2013, p. 21845; Hamilton testimony, October 7, 2013, p. 28537.
- <sup>272</sup> Exhibit 9449, pp. 734–5; Jeffreys testimony, October 3, 2014, pp. 28171–2 and 28176.
- <sup>273</sup> Hamilton testimony, October 7, 2013, p. 28537.
- <sup>274</sup> Hamilton testimony, October 7, 2013, pp. 28537–9.
- <sup>275</sup> Officer testimony, August 22, 2013, pp. 21845–6.
- <sup>276</sup> Officer testimony, August 22, 2013, p. 21846; Exhibit 3743, p. 041.
- <sup>277</sup> Officer testimony, August 22, 2013, pp. 21846–9.
- <sup>278</sup> Officer testimony, August 22, 2013, p. 21847.
- <sup>279</sup> Exhibit 3743, p. 042; Officer testimony, August 22, 2013, pp. 21849–50.
- <sup>280</sup> Officer testimony, August 22, 2013, pp. 21849–50; Exhibit 3743, p. 042.
- <sup>281</sup> Officer testimony, August 22, 2013, p. 21850.
- <sup>282</sup> Officer testimony, August 22, 2013, pp. 21850–1; Exhibit 3743, p. 042.
- <sup>283</sup> Officer testimony, August 22, 2013, p. 21851.
- <sup>284</sup> Officer testimony, August 22, 2013, pp. 21851–2.
- <sup>285</sup> Officer testimony, August 22, 2013, pp. 21852–3.
- <sup>286</sup> Officer testimony, August 22, 2013, p. 21853.
- <sup>287</sup> Officer testimony, August 22, 2013, pp. 21854–5.
- <sup>288</sup> Officer testimony, August 22, 2013, p. 21854.
- <sup>289</sup> Officer testimony, August 22, 2013, pp. 21855–6.
- <sup>290</sup> Officer testimony, August 22, 2013, pp. 21847–8 and 21856; Neadles testimony, September 12, 2013, pp. 25571–2.
- <sup>291</sup> Exhibit 3743, p. 043.
- <sup>292</sup> Officer testimony, August 22, 2013, pp. 21847–8 and 21856–7; Neadles testimony, September 12, 2013, pp. 25572–3.



- <sup>293</sup> Hamilton testimony, October 7, 2013, p. 28540; deBortoli testimony, October 7, 2013, pp. 28459–60; Jeffreys testimony, October 3, 2013, pp. 28176–8; Exhibit 9449, p. 735.
- <sup>294</sup> Exhibit 3743, p. 043.
- <sup>295</sup> Needles testimony, September 12, 2013, pp. 25573–4.
- <sup>296</sup> Exhibit 3743, p. 044.
- <sup>297</sup> Hamilton testimony, October 7, 2013, p. 28542.
- <sup>298</sup> Bray testimony, October 4, 2013, pp. 28344–5.
- <sup>299</sup> Hamilton testimony, October 7, 2013, p. 28542.
- <sup>300</sup> Exhibit 9911; Bray testimony, October 4, 2013, pp. 28343–4.
- <sup>301</sup> Cranford testimony, September 9, 2013, pp. 24849–50.
- <sup>302</sup> Cranford testimony, September 9, 2013, pp. 24850–1.
- <sup>303</sup> Needles testimony, September 12, 2013, pp. 25544–7.
- <sup>304</sup> Comella testimony, September 5, 2013, pp. 24278–9.
- <sup>305</sup> Comella testimony, September 5, 2013, pp. 24279–81 and 24357–8; Exhibit 6393, p. 1866.
- <sup>306</sup> Comella testimony, September 5, 2013, pp. 24279–81; Exhibit 6393, p. 1866.
- <sup>307</sup> Comella testimony, September 5, 2013, pp. 24358–60; Exhibit 6393, p. 1866.
- <sup>308</sup> Exhibit 7545, p. 02; Cranford testimony, September 9, 2013, p. 24851.
- <sup>309</sup> Cranford testimony, September 9, 2013, p. 24852; Exhibit 7545.
- <sup>310</sup> Needles testimony, September 12, 2013, pp. 25547–8.
- <sup>311</sup> Sanders testimony, October 4, 2013, p. 28331.
- <sup>312</sup> Sanders testimony, October 4, 2013, pp. 28331–2.
- <sup>313</sup> Chambers testimony, September 18, 2013, pp. 26177–8.
- <sup>314</sup> Chambers testimony, September 18, 2013, p. 26178; Exhibit 7195.
- <sup>315</sup> Exhibit 7196; Chambers testimony, September 18, 2013, p. 26178.
- <sup>316</sup> Chambers testimony, September 18, 2013, pp. 26178–82.
- <sup>317</sup> Exhibit 7198.
- <sup>318</sup> Exhibit 7198.
- <sup>319</sup> Chambers testimony, September 18, 2013, pp. 26183–6.
- <sup>320</sup> Chambers testimony, September 18, 2013, pp. 26183–6.
- <sup>321</sup> Exhibit 7197; Chambers testimony, September 18, 2013, pp. 26178–82.
- <sup>322</sup> Chambers testimony, September 18, 2013, pp. 26186–9; Exhibit 7200.
- <sup>323</sup> Exhibit 6954.
- <sup>324</sup> McGuinty testimony, October 9, 2013, pp. 28948–50; see also O’Leary testimony, September 17, 2013, pp. 25963–4.
- <sup>325</sup> O’Leary testimony, September 17, 2013, pp. 25964–6; Exhibit 6997.
- <sup>326</sup> O’Leary testimony, September 17, 2013, p. 25965.
- <sup>327</sup> O’Leary testimony, September 17, 2013, pp. 25966–7.
- <sup>328</sup> Jones testimony, September 26, 2013, pp. 27432–5; see also Sanders testimony, October 4, 2013, pp. 28321–2.
- <sup>329</sup> Exhibit 5052; Jones testimony, September 26, 2013, pp. 27413–18.
- <sup>330</sup> Jones testimony, September 26, 2013, pp. 27432–5.
- <sup>331</sup> Jones testimony, September 26, 2013, pp. 27418–19.
- <sup>332</sup> Jones testimony, September 26, 2013, pp. 27420–3.
- <sup>333</sup> Jones testimony, September 26, 2013, p. 27419; see also Exhibit 7021, p. 115.
- <sup>334</sup> Needles testimony, September 12, 2013, pp. 25575–6.
- <sup>335</sup> Glavin testimony, October 1, 2013, pp. 27735–9.
- <sup>336</sup> Hefkey testimony, October 8, 2013, pp. 28642–3 and 28645–7; Exhibit 7812, p. 008.
- <sup>337</sup> Needles testimony, September 12, 2013, pp. 25577–8.
- <sup>338</sup> Needles testimony, September 12, 2013, p. 25579.
- <sup>339</sup> Hefkey testimony, October 8, 2013, pp. 28642–3 and 28645–7; Exhibit 7812, p. 008.
- <sup>340</sup> Hefkey testimony, October 8, 2013, pp. 28642–3 and 28645–7 and Exhibit 7812, p. 008.
- <sup>341</sup> Needles testimony, September 12, 2013, p. 25579.
- <sup>342</sup> Priestly testimony, October 2, 2013, p. 27817; Glavin testimony, October 1, 2013, pp. 27739–44.
- <sup>343</sup> Exhibit 9232, p. 21.
- <sup>344</sup> Chambers testimony, September 18, 2013, pp. 26237–8.
- <sup>345</sup> Needles testimony, September 12, 2013, pp. 25580–3; Exhibit 7812, p. 008.
- <sup>346</sup> Needles testimony, September 12, 2013, p. 25580.
- <sup>347</sup> Hefkey testimony, October 8, 2013, pp. 28643–5; Exhibit 7812, p. 008.
- <sup>348</sup> Cranford testimony, September 9, 2013, pp. 24937–8.
- <sup>349</sup> Needles testimony, September 12, 2013, pp. 25581–2.
- <sup>350</sup> Hefkey testimony, October 8, 2013, pp. 28643–5; Exhibit 7812, p. 008.
- <sup>351</sup> Hefkey testimony, October 8, 2013, pp. 28643–5; Exhibit 7812, p. 008.
- <sup>352</sup> Hefkey testimony, October 8, 2013, pp. 28647–8; Exhibit 7812, p. 008.
- <sup>353</sup> Needles testimony, September 12, 2013, p. 25583.
- <sup>354</sup> Hefkey testimony, October 8, 2013, pp. 28647–50; Exhibit 7812, p. 008.
- <sup>355</sup> Glavin testimony, October 1, 2013, pp. 27739–40.
- <sup>356</sup> Priestly testimony, October 2, 2013, p. 27808; Exhibits 6622 and 9571.
- <sup>357</sup> Glavin testimony, October 1, 2013, pp. 27739–41; see also notes from Sgt. Glavin at Exhibit 7617, p. 192.
- <sup>358</sup> Comella testimony, September 5, 2013, pp. 24281–5; Exhibit 6393, p. 1866.
- <sup>359</sup> Priestly testimony, October 2, 2013, pp. 27816–17.
- <sup>360</sup> Comella testimony, September 5, 2013, pp. 24281–5; Exhibit 6393, p. 1866.
- <sup>361</sup> Exhibit 9555.
- <sup>362</sup> Priestly testimony, October 2, 2013, pp. 27824–9; Exhibit 7950.
- <sup>363</sup> Priestly testimony, October 2, 2013, pp. 27829–34; Exhibit 9899 (see also Exhibit 9578).
- <sup>364</sup> Priestly testimony, October 2, 2013, pp. 27834–5; Exhibit 9900.
- <sup>365</sup> Priestly testimony, October 2, 2013, pp. 27836–7.
- <sup>366</sup> Priestly testimony, October 2, 2013, pp. 27817–18.
- <sup>367</sup> Priestly testimony, October 2, 2013, pp. 27818–19.
- <sup>368</sup> Priestly testimony, October 2, 2013, p. 27820.
- <sup>369</sup> Glavin testimony, October 1, 2013, pp. 27742–3.
- <sup>370</sup> Glavin testimony, October 1, 2013, pp. 27767–8.
- <sup>371</sup> Bailey testimony, August 27, 2013, pp. 22780–1; Exhibit 6374, p. 05; Gillespie testimony, September 3, 2013, pp. 23747–8; Exhibit 6378, p. 31.
- <sup>372</sup> Bailey testimony, August 27, 2013, pp. 22781–2; Exhibit 6374, p. 05; see also Cox testimony, August 26, 2013, p. 22396; Exhibit 6377, p. 009.
- <sup>373</sup> Exhibit 7617, p. 192.
- <sup>374</sup> Glavin testimony, October 1, 2013, pp. 27739–44; Exhibit 5971; Exhibit 7617, pp. 192–3.
- <sup>375</sup> Priestly testimony, October 2, 2013, pp. 27822–3.
- <sup>376</sup> Guy testimony, September 24, 2013, p. 27139; see also Fowlds testimony, September 19, 2013, pp. 26369–71; Exhibit 6242, p. 183.
- <sup>377</sup> Needles testimony, September 12, 2013, p. 25592.
- <sup>378</sup> Needles testimony, September 12, 2013, pp. 25592–3; Exhibit 7949.
- <sup>379</sup> Needles testimony, September 12, 2013, pp. 25594–6.
- <sup>380</sup> Needles testimony, September 12, 2013, pp. 25596–7.



- <sup>381</sup> McCallion testimony, September 6, 2013, pp. 24651–3; Exhibit 7949.
- <sup>382</sup> Priestly testimony, October 2, 2013, pp. 27914–5; Exhibit 9897.
- <sup>383</sup> Comella testimony, September 5, 2013, pp. 24292–3.
- <sup>384</sup> Exhibit 7477, p. 160.
- <sup>385</sup> Exhibit 7477, p. 159; Needles testimony, September 12, 2013, pp. 25587–90.
- <sup>386</sup> Needles testimony, September 12, 2013, pp. 25587–8.
- <sup>387</sup> Needles testimony, September 12, 2013, p. 25589.
- <sup>388</sup> Priestly testimony, October 2, 2013, p. 27913; Exhibit 9340.
- <sup>389</sup> Priestly testimony, October 2, 2013, pp. 27913–14.
- <sup>390</sup> McGuinty testimony, October 9, 2013, pp. 28950–1.
- <sup>391</sup> Hefkey testimony, October 8, 2013, pp. 28650–2; Exhibit 7812, p. 009.
- <sup>392</sup> Hefkey testimony, October 8, 2013, p. 28650; Exhibit 7812, p. 010.
- <sup>393</sup> Hefkey testimony, October 8, 2013, pp. 28651–2.
- <sup>394</sup> Hefkey testimony, October 8, 2013, pp. 28653–5.
- <sup>395</sup> Hefkey testimony, October 8, 2013, pp. 28655–7.
- <sup>396</sup> Selvers testimony, September 10, 2013, p. 25096.
- <sup>397</sup> Selvers testimony, September 10, 2013, p. 25100.
- <sup>398</sup> Selvers testimony, September 10, 2013, p. 25098.
- <sup>399</sup> Selvers testimony, September 10, 2013, pp. 25100–1.
- <sup>400</sup> Selvers testimony, September 10, 2013, pp. 25101–2; Exhibit 6246, p.010.
- <sup>401</sup> Selvers testimony, September 10, 2013, pp. 25101–2.
- <sup>402</sup> Selvers testimony, September 10, 2013, p. 25102.
- <sup>403</sup> Kerr testimony, September 25, 2013, pp. 27348–9; Exhibit 6402.
- <sup>404</sup> Kerr testimony, September 25, 2013, pp. 27349–50.
- <sup>405</sup> Kerr testimony, September 25, 2013, pp. 27350–1.
- <sup>406</sup> Latulippe and Perizzolo testimony, August 7, 2013, pp. 19928–30.
- <sup>407</sup> Latulippe and Perizzolo testimony, August 7, 2013, pp. 19931–2.
- <sup>408</sup> Cox testimony, August 26, 2013, pp. 22396–8; Exhibit 6377, p. 009; Bailey testimony, August 27, 2013, pp. 22782–5; Exhibit 6374, p. 05.
- <sup>409</sup> Hulsman testimony, August 28, 2013, pp. 23075–7.
- <sup>410</sup> Hulsman testimony, August 28, 2013, pp. 23073–9; Exhibit 7010, p. 005; Exhibit 7924, p. 100.
- <sup>411</sup> McCallion testimony, September 6, 2013, pp. 24651–3; Exhibit 7949.
- <sup>412</sup> Gillespie testimony, September 3, 2013, pp. 23748–57; Exhibit 6378, p. 31.
- <sup>413</sup> Gillespie testimony, September 3, 2013, pp. 23748–57; Exhibit 6378, pp. 31–32.
- <sup>414</sup> Gillespie testimony, September 3, 2013, pp. 23748–57; Exhibit 6378, pp. 31–32.
- <sup>415</sup> Gillespie testimony, September 3, 2013, pp. 23748–57; Exhibit 6378, p. 31.
- <sup>416</sup> Bailey testimony, August 27, 2013, p. 22785; Exhibit 6374, p. 6; Cox testimony, August 26, 2013, p. 22398; Exhibit 6377, p. 009.
- <sup>417</sup> O’Leary testimony, September 17, 2013, p. 25967.
- <sup>418</sup> O’Leary testimony, September 17, 2013, pp. 25967–8; Exhibit 8394, p. 126.
- <sup>419</sup> O’Leary testimony, September 17, 2013, pp. 25968–9; Exhibit 8394, p. 126.
- <sup>420</sup> O’Leary testimony, September 17, 2013, p. 25969.
- <sup>421</sup> O’Leary testimony, September 17, 2013, pp. 25969–70.
- <sup>422</sup> Exhibit 9140, pp. 7–8.
- <sup>423</sup> O’Leary testimony, September 17, 2013, pp. 25970–1.
- <sup>424</sup> O’Leary testimony, September 17, 2013, p. 25971.
- <sup>425</sup> O’Leary testimony, September 17, 2013, pp. 25972–3.
- <sup>426</sup> O’Leary testimony, September 17, 2013, pp. 25973–4.
- <sup>427</sup> O’Leary testimony, September 17, 2013, p. 25974.
- <sup>428</sup> O’Leary testimony, September 17, 2013, p. 25975.
- <sup>429</sup> O’Leary testimony, September 17, 2013, pp. 25975–6.
- <sup>430</sup> O’Leary testimony, September 17, 2013, pp. 25976–80; Exhibit 8416, p. 139.
- <sup>431</sup> O’Leary testimony, September 17, 2013, p. 25979.
- <sup>432</sup> McGuinty testimony, October 9, 2013, pp. 28951–4; Exhibits 8422 and 8424.
- <sup>433</sup> McGuinty testimony, October 9, 2013, pp. 28952–4; Exhibit 8422.
- <sup>434</sup> McGuinty testimony, October 9, 2013, pp. 28952–4; Exhibit 8422.
- <sup>435</sup> McGuinty testimony, October 9, 2013, pp. 28951–4; Exhibits 8422 and 8424.
- <sup>436</sup> O’Leary testimony, September 17, 2013, pp. 25980–1.
- <sup>437</sup> O’Leary testimony, September 17, 2013, p. 25981.
- <sup>438</sup> O’Leary testimony, September 17, 2013, p. 25982.
- <sup>439</sup> Officer testimony, August 22, 2013, p. 21857; Exhibit 3743, p. 045.
- <sup>440</sup> Officer testimony, August 22, 2013, p. 21858; Exhibit 3743, p. 046; Needles testimony, September 12, 2013, pp. 25598–612; Exhibit 8035, p. 228.
- <sup>441</sup> Needles testimony, September 12, 2013, p. 25598.
- <sup>442</sup> Needles testimony, September 12, 2013, p. 25599.
- <sup>443</sup> Needles testimony, September 12, 2013, p. 25600.
- <sup>444</sup> Needles testimony, September 12, 2013, pp. 25601–3.
- <sup>445</sup> Needles testimony, September 12, 2013, pp. 25603–6.
- <sup>446</sup> Needles testimony, September 12, 2013, p. 25606.
- <sup>447</sup> Needles testimony, September 12, pp. 25610–11.
- <sup>448</sup> Needles testimony, September 12, pp. 25611–12.
- <sup>449</sup> Jeffreys testimony, October 3, 2013, pp. 28186–7.
- <sup>450</sup> Exhibit 7296.
- <sup>451</sup> Jeffreys testimony, October 3, 2013, p. 28187.
- <sup>452</sup> Officer testimony, August 22, 2013, p. 21858.
- <sup>453</sup> Officer testimony, August 22, 2013, p. 21859.
- <sup>454</sup> Mantha testimony, September 23, 2013, pp. 26780–1.
- <sup>455</sup> Officer testimony, August 22, 2013, p. 21860.
- <sup>456</sup> Officer testimony, August 22, 2013, p. 21861.
- <sup>457</sup> Needles testimony, September 12, 2013, pp. 25612–13; Exhibit 7477, p. 158.
- <sup>458</sup> Needles testimony, September 12, 2013, pp. 25613–14; Exhibit 7472, pp. 003–004.
- <sup>459</sup> Needles testimony, September 12, 2013, pp. 25614–16.
- <sup>460</sup> Needles testimony, September 12, 2013, pp. 25618–19.
- <sup>461</sup> Exhibit 7472, pp. 05–06.
- <sup>462</sup> Needles testimony, September 12, 2013, pp. 25621–2.
- <sup>463</sup> Needles testimony, September 12, 2013, p. 25622.
- <sup>464</sup> Needles testimony, September 12, 2013, pp. 25623–4.
- <sup>465</sup> Needles testimony, September 12, 2013, pp. 25625–6; Exhibit 7472, p. 007.
- <sup>466</sup> Needles testimony, September 12, 2013, p. 25626; Exhibit 7472, p. 008.
- <sup>467</sup> Needles testimony, September 12, 2013, p. 25627.
- <sup>468</sup> Needles testimony, September 12, 2013, pp. 25627–8; Exhibit 7472, pp. 013–014.
- <sup>469</sup> Needles testimony, September 12, 2013, p. 25628.
- <sup>470</sup> Needles testimony, September 12, 2013, pp. 25628–9.
- <sup>471</sup> Selvers testimony, September 10, 2013, pp. 25102–3, 25123–4; Exhibit 6246, p. 010.
- <sup>472</sup> Gillespie testimony, September 3, 2013, pp. 23757–63; Exhibit 6378, p. 32.
- <sup>473</sup> Gillespie testimony, September 3, 2013, pp. 23757–63; Exhibit 6378, p. 32.
- <sup>474</sup> Selvers testimony, September 10, 2013, pp. 25102–3; Exhibit 6246, p. 010.

- <sup>475</sup> Selvers testimony, September 10, 2013, p. 25126.
- <sup>476</sup> Needles testimony, September 12, 2013, p. 25629; Exhibit 7812, p. 012.
- <sup>477</sup> Needles testimony, September 12, 2013, p. 25629.
- <sup>478</sup> Exhibit 7812, p. 013.
- <sup>479</sup> Priestly testimony, October 2, 2013, pp. 27838–40; Exhibit 6622.
- <sup>480</sup> Priestly testimony, October 2, 2013, p. 27844.
- <sup>481</sup> Priestly testimony, October 2, 2013, pp. 27841–3.
- <sup>482</sup> Priestly testimony, October 2, 2013, pp. 27844–5.
- <sup>483</sup> Priestly testimony, October 2, 2013, p. 27846.
- <sup>484</sup> Priestly testimony, October 2, 2013, p. 27847.
- <sup>485</sup> Priestly testimony, October 2, 2013, p. 27848.
- <sup>486</sup> Exhibit 9449, p. 739; Jeffreys testimony, October 3, 2013, p. 28188.
- <sup>487</sup> Jeffreys testimony, October 3, 2013, pp. 28188–9.
- <sup>488</sup> Priestly testimony, October 2, 2013, pp. 27850–1.
- <sup>489</sup> Comella testimony, September 5, 2013, pp. 24305–9; Exhibits 7296 and 2115.
- <sup>490</sup> Jeffreys testimony, October 3, 2013, pp. 28188–9.
- <sup>491</sup> Priestly testimony, October 2, 2013, p. 27849.
- <sup>492</sup> Jeffreys testimony, October 3, 2013, p. 28191.
- <sup>493</sup> Priestly testimony, October 2, 2013, p. 27917.
- <sup>494</sup> Jeffreys testimony, October 3, 2013, pp. 281967.
- <sup>495</sup> Exhibit 7296; Jeffreys testimony, October 3, 2013, pp. 28188–9.
- <sup>496</sup> Jeffreys testimony, October 3, 2013, p. 28189.
- <sup>497</sup> Jeffreys testimony, October 3, 2013, p. 28200.
- <sup>498</sup> Needles testimony, September 12, 2013, p. 25632.
- <sup>499</sup> Priestly testimony, October 2, 2013, p. 27852; Exhibit 7296, p. 232.
- <sup>500</sup> Priestly testimony, October 2, 2013, p. 27852.
- <sup>501</sup> Priestly testimony, October 2, 2013, p. 27853; Exhibit 7296, p. 232.
- <sup>502</sup> Priestly testimony, October 2, 2013, p. 27853.
- <sup>503</sup> Priestly testimony, October 2, 2013, p. 27854; Exhibit 7296, p. 232.
- <sup>504</sup> Priestly testimony, October 2, 2013, p. 27854.
- <sup>505</sup> Priestly testimony, October 2, 2013, pp. 27854; Exhibit 7296, p. 232.
- <sup>506</sup> Priestly testimony, October 2, 2013, pp. 27854–5.
- <sup>507</sup> Priestly testimony, October 2, 2013, p. 27855; Exhibit 7296, p. 232.
- <sup>508</sup> Priestly testimony, October 2, 2013, p. 27855.
- <sup>509</sup> Priestly testimony, October 2, 2013, pp. 27855–6.
- <sup>510</sup> Priestly testimony, October 2, 2013, p. 27856; Exhibit 7293, p. 232.
- <sup>511</sup> Priestly testimony, October 2, 2013, p. 27856; Exhibit 7296.
- <sup>512</sup> Priestly testimony, October 2, 2013, p. 27856.
- <sup>513</sup> Priestly testimony, October 2, 2013, pp. 27856–7.
- <sup>514</sup> Priestly testimony, October 2, 2013, p. 27857.
- <sup>515</sup> Priestly testimony, October 2, 2013, pp. 27857–8.
- <sup>516</sup> Priestly testimony, October 2, 2013, p. 27858.
- <sup>517</sup> Priestly testimony, October 2, 2013, p. 27859; Exhibit 7296, p. 232.
- <sup>518</sup> Priestly testimony, October 2, 2013, pp. 27859–60.
- <sup>519</sup> Priestly testimony, October 2, 2013, p. 27860.
- <sup>520</sup> Priestly testimony, October 2, 2013, pp. 27861–2.
- <sup>521</sup> Priestly testimony, October 2, 2013, pp. 27862–3.
- <sup>522</sup> Priestly testimony, October 2, 2013, p. 27863.
- <sup>523</sup> Priestly testimony, October 2, 2013, p. 27864.
- <sup>524</sup> Priestly testimony, October 2, 2013, p. 27865.
- <sup>525</sup> Priestly testimony, October 2, 2013, p. 27866.
- <sup>526</sup> Priestly testimony, October 2, 2013, p. 27867.
- <sup>527</sup> Exhibit 8035, p. 4232.
- <sup>528</sup> Exhibit 6622, p. 004.
- <sup>529</sup> Priestly testimony, October 2, 2013, p. 27868; see also Comella testimony, September 5, 2013, pp. 24305–9, and Exhibits 7296 and 2115.
- <sup>530</sup> Priestly testimony, October 2, 2013, pp. 27868–9; Exhibit 7296, p. 232.
- <sup>531</sup> Priestly testimony, October 2, 2013, p. 27869.
- <sup>532</sup> Priestly testimony, October 2, 2013, p. 27870.
- <sup>533</sup> Priestly testimony, October 2, 2013, pp. 27871–2.
- <sup>534</sup> Needles testimony, September 12, 2013, pp. 25630–1; Exhibit 7477, pp. 157–8.
- <sup>535</sup> Needles testimony, September 12, 2013, pp. 25630–1.
- <sup>536</sup> Priestly testimony, October 2, 2013, p. 27867; Exhibit 6622.
- <sup>537</sup> Bailey testimony, August 27, 2013, pp. 22785–7; Exhibit 6374; Cox testimony, August 26, 2013, pp. 22400–8; Exhibit 6377, p. 009.
- <sup>538</sup> Priestly testimony, October 2, 2013, pp. 27874–5; Exhibits 9580 and 9897.
- <sup>539</sup> Priestly testimony, October 2, 2013, p. 27876.
- <sup>540</sup> Priestly testimony, October 2, 2013, p. 27877; Exhibit 9898.
- <sup>541</sup> Priestly testimony, October 2, 2013, p. 27880.
- <sup>542</sup> Priestly testimony, October 2, 2013, pp. 27881 and 27884.
- <sup>543</sup> Priestly testimony, October 2, 2013, pp. 27884–6.
- <sup>544</sup> Priestly testimony, October 2, 2013, p. 27886.
- <sup>545</sup> Priestly testimony, October 2, 2013, p. 27884.
- <sup>546</sup> Priestly testimony, October 2, 2013, pp. 27887–8.
- <sup>547</sup> Priestly testimony, October 2, 2013, pp. 27883 and 27888–9.
- <sup>548</sup> Priestly testimony, October 2, 2013, pp. 27889–90.
- <sup>549</sup> Priestly testimony, October 2, 2013, p. 27890.
- <sup>550</sup> Priestly testimony, October 2, 2013, p. 27891.
- <sup>551</sup> Priestly testimony, October 2, 2013, p. 27892.
- <sup>552</sup> Priestly testimony, October 2, 2013, p. 27892.
- <sup>553</sup> Priestly testimony, October 2, 2013, pp. 27892–3.
- <sup>554</sup> Priestly testimony, October 2, 2013, p. 27893.
- <sup>555</sup> Priestly testimony, October 2, 2013, p. 27894.
- <sup>556</sup> Priestly testimony, October 2, 2013, pp. 27895–6.
- <sup>557</sup> Priestly testimony, October 2, 2013, p. 27896.
- <sup>558</sup> Priestly testimony, October 2, 2013, pp. 27896–7.
- <sup>559</sup> Comella testimony, September 5, 2013, pp. 24305–9; Exhibits 7296 and 2115.
- <sup>560</sup> Comella testimony, September 5, 2013, pp. 24363–5.
- <sup>561</sup> Jeffreys testimony, October 3, 2013, pp. 28211–12.
- <sup>562</sup> Jeffreys testimony, October 3, 2013, p. 28213.
- <sup>563</sup> Jeffreys testimony, October 3, 2013, p. 28213.
- <sup>564</sup> Exhibit 6377, p. 009.
- <sup>565</sup> Cox testimony, August 26, 2013, pp. 22400–8; Exhibit 6377, p. 009.
- <sup>566</sup> Cox testimony, August 26, 2013, pp. 22400–8; Exhibit 6377, p. 009.
- <sup>567</sup> Gillespie testimony, September 3, 2013, pp. 23768–9; Bailey testimony, August 27, 2013, pp. 22788–9; Cox testimony, August 26, 2013, p. 22409; Exhibit 6378, p. 034; Exhibit 6374, p. 006; Exhibit 6377, p. 009.
- <sup>568</sup> Gillespie testimony, September 3, 2013, p. 23769; Exhibit 6378, p. 035.
- <sup>569</sup> Bailey testimony, August 27, 2013, pp. 22788–9; Cox testimony, August 26, 2013, p. 22409; Exhibit 6378, p. 034; Exhibit 6374, p. 006; Exhibit 6377, p. 009.
- <sup>570</sup> Exhibit 6378, pp. 035–036.
- <sup>571</sup> Exhibit 6378, pp. 036–7.
- <sup>572</sup> Gillespie testimony, September 3, 2013, pp. 23775–7.
- <sup>573</sup> Cox testimony, August 26, 2013, pp. 22409–11.
- <sup>574</sup> Fowlds testimony, September 19, 2013, pp. 26358–60.

- <sup>575</sup> Cox testimony, August 26, 2013, pp. 22411–14;  
Exhibit 6377, pp. 009–010.
- <sup>576</sup> Exhibit 6374, pp. 06–09.
- <sup>577</sup> Bailey testimony, August 27, 2013, p. 22794;  
Exhibit 6374, pp. 06–09.
- <sup>578</sup> Gillespie testimony, September 3, 2014, pp. 23764–5.
- <sup>579</sup> Exhibit 6378, pp. 033–034.
- <sup>580</sup> Gillespie testimony, September 3, 2014, p. 23767.
- <sup>581</sup> Lacroix Testimony, October 3, 2013, pp. 28016–20.
- <sup>582</sup> McGuinty testimony, October 9, 2013, pp. 28954–5.
- <sup>583</sup> Priestly testimony, October 2, 2013, pp. 27898–9; Exhibit 6622.
- <sup>584</sup> Priestly testimony, October 2, 2013, pp. 27900–2.
- <sup>585</sup> Priestly testimony, October 2, 2013, pp. 27900–2.



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## A sniffer dog search of the collapse zone at 6 a.m. indicates two deceased

The Priestly demolition was complete at approximately 6 a.m. The immediate next step was to use a dog to conduct a search for live victims in the collapse zone. The OPP's Cst. Dan Bailey was asked to perform this search and he decided to use Dare, a dog cross-trained for both cadaver and live searches.<sup>1</sup>

Cst. Bailey started his search of the collapse zone with Dare at or around 6 a.m.<sup>2</sup> As his notes indicate, Dare gave indications only of deceased victims:

Sent HUSAR [live search\*] dog Dare back into area of collapsed structure / rubble pile. K9 Dare searched in a northerly direction moving along east wall of building approximately 25 ft north of my location. K9 Dare runs up to small void area in rubble pile ... sticks his head down in along wall tail wagging, quickly turns and sits looking at me with tail wagging indicating cadaver indication / find. Recast Dare away from area direct over to west side of rubble pile. Dare searches across pile and over to last area of interest where previous indication of live find was made a couple days previous. Dare again sniffs diffused scent in area then smells small area / crack in cement pads. Sticks head down into area turns and looks at me with tail wagging furiously. Request Dare to find victim – Dare sticks head back into area of cracks turns looks at me a 2nd time. Tail wagging and refusing to leave area of odour.

Recast Dare back up to North / North east area of pile to search for any additional victims / cadavers. Dare searches with negative results. Recast Dare over to West side of pile. Dare only returns ... to centre of pile in last area of interest where detecting cadaver. Recall Dare off of rubble pile and advised Sgt. [Jamie] Gillespie of findings of at least 2 cadavers and no live victims exist [in] area of rubble pile where original collapse occurred. Return to cruiser with Dare.<sup>3</sup>

Cst. Bailey explained these results during his testimony. Dare had indicated two deceased persons in the collapse zone. One of those hits was where Dare had formerly indicated a live person. The hits corresponded to the locations where Mrs. Perizzolo and Ms. Aylwin were soon to be removed from the debris. Based on all his training with Dare, Cst. Bailey believed that both victims were deceased at the time of this search.<sup>4</sup>

## The coroner is called to the scene early in the morning of June 27

Dr. Marc Bradford, the coroner who investigated the deaths of Doloris Perizzolo and Lucie Aylwin, was contacted by the OPP between 5 a.m. and 6 a.m. on June 27 and asked to go to the scene of the collapse. He arrived at 6:50 a.m.<sup>5</sup>

Dr. Bradford runs a general practice as a family physician in Blind River, Ontario. He became a part-time coroner in 2000, one of three such coroners serving an area from Spanish to Echo Bay and including Elliot Lake. Since 2000, he had investigated 250 cases, or approximately 20 per year.<sup>†</sup>

• • • • •

\* Bailey testimony, August 27, 2013, pp. 22735–6. Cst. Bailey explained in testimony that “HUSAR” in his notes, in this context, was not a reference to TF3 or to a TF3 dog, but to the fact that the dog was being used for a live search. By writing “HUSAR,” he was distinguishing between use of a cadaver dog and a live dog.

† Bradford testimony, August 29, 2013, pp. 23134–7. Dr. Bradford said it is typical for coroners to be part time. Only a few coroners work full time in the province, usually in the major city centres. All coroners are physicians. The Chief Coroner's Office offers a training session lasting for a few days for each new coroner, with regular additional training.

As a general rule, coroners are called to investigate any sudden and unexpected death and to answer five key questions. Who died? When did they die? Where did they die? How? By what means: accident, homicide, or undetermined?\*

Dr. Bradford was asked about the coroner's jurisdiction at the scene. Although he could not say with certainty from a legal perspective, he explained that, typically, when the coroner arrives at the scene, he assumes authority over the deceased and any aspect of the scene required for investigation.

Once the bodies are removed and the need for investigation has ended, the coroner releases the scene. The coroner may keep jurisdiction over the bodies for investigative purposes and, if questions remain, request that an autopsy be carried out by a pathologist.<sup>6</sup> Dr. Bradford requested autopsies in this case. I discuss those results later in the Report.

When Dr. Bradford arrived in Elliot Lake early in the morning of June 27, he met with Cst. Dale Burns, an OPP identification officer. The identification constable's duty is to accompany the coroner and document his actions. Cst. Burns took detailed notes, which I consider to be reliable.<sup>7</sup>

On arrival at the site, the coroner was not aware of the number of victims, but he knew there were at least two. He understood at the time that both were dead: "We were called because they were dead, yes, because it was assumed that they were dead."<sup>8</sup> He went directly to the forensic tent set up in the parking lot and waited for the bodies to be uncovered, which he was advised would soon occur.<sup>9</sup>

Cst. Burns's notes indicate that, at 7:30 a.m., Dr. Bradford had identified four body removal services in the area. It had been determined that the bodies should be removed with the assistance of a funeral director and then transported to Sudbury for autopsies. Because Dr. Bradford did not know the exact number of victims, provision was initially made for four bodies. By 7:47 a.m., Dr. Bradford was told that the dog search had turned up two cadaver hits, but no live ones.<sup>10</sup>

**As a general rule, coroners are called to investigate any sudden and unexpected death and to answer five key questions. Who died? When did they die? Where did they die? How? By what means: accident, homicide, or undetermined?**

## Rescue workers focus first on recovering Mrs. Perizzolo

In the meantime, rescue workers still had a significant amount of work to do before the bodies of Mrs. Perizzolo and Ms. Aylwin could be removed. Ryan Priestly had used his equipment to make the area safe enough for access by the rescue workers, but significant amounts of rubble and pieces of broken precast slabs still needed to be moved before access to the bodies could be had.<sup>11</sup>

The initial focus was on the victim located near the telephone booths, on the east side of the collapse zone. The rescuers believed this victim had long since been deceased.

.....

\* Bradford testimony, August 29, 2013, pp. 23138–40. Dr. Bradford explained that coroners also investigate certain types of deaths that are not sudden and unexpected. Examples include every 10th death in a long-term care facility, and deaths while incarcerated.



Mr. Priestly gave two reasons for the initial focus on the area where Mrs. Perizzolo was located. First, her body was more clearly visible – her foot and hand could be seen, and less work was required to get to the body.<sup>12</sup> The more important reason, according to Mr. Priestly at least, was that the debris above Mrs. Perizzolo needed to be moved in any event before he could safely access the debris above Ms. Aylwin's body. As he put it, Mrs. Perizzolo's body was going to "come to the top sooner by the way the precast had fallen." Despite his advanced equipment, he did not feel he could have safely removed the debris above Ms. Aylwin first:

Q. It makes sense, but we've seen the wonders that your equipment can achieve here. I would have thought that there would have been a way for you to immediately attempt to gain access to that victim that is, as you've described, more in the middle; was that not possible?

A. Well, the problem is that all the work that we've done to date with the machinery is there is no victim there, so ultimately the work that you do is – yes, it's careful, and it's controlled, but ... you're not trying to work over top of someone.

When you're trying to empty out the pile to find someone in the pile ... I don't want even the weight of this cup of water to fall on it.<sup>13</sup>

Mr. Priestly and the rescue workers removed the slabs and debris by grabbing the slabs with the Priestly grapple and by slinging the slabs with wire slings and hoisting them off the pile. Sometimes the pre-cast slabs were so broken up that the operation required a high degree of precision and delicacy.<sup>14</sup> Mr. Priestly felt that he and the rescue workers worked urgently, but carefully, in an attempt to remove the victims and with a hope that someone was alive:

I think it was very urgent. I think that, you know, we literally just tried to go so carefully not to do any further damage to the victims, always hoping that there's a chance that they're alive. So we just tried to do it in such a systematic manner that we didn't apply any further pressure to the pile constantly. So we just lifted the pieces, piece by piece, and once they got the first victim, they literally, like, dug it out by hand, the rescue workers, the fine material around the victim.<sup>15</sup>



**Figure 2.7.1 Rubble pile near first victim recovered, after removal of several large slabs**

Source Exhibit 9905

Figure 2.7.1 shows the rubble pile near Mrs. Perizzolo, after several large slabs had been removed. Mr. Priestly explained that he initially lifted the large slabs (shown on the ground in the photo) off the pile and into the air, using his crane and slinging them. He then placed them on the ground and, using chains, dragged them back and out of the way.<sup>16</sup>

Staff Insp. William Neadles sent an email update at 7:59 a.m. In contrast to Mr. Priestly's suggestion that he was hopeful they might find a survivor, Staff Insp. Neadles's language in this contemporaneous email suggests that the operation was viewed that morning as a recovery:

The heavy lifting is done. The Search and Cadaver Dogs [sic] and there was two Cadaver indications.

We are now removing smaller debris to make direct contact with the Victims.

The Coroner is present to deal with the removal once pronounced by the HUSAR Team Doctor.<sup>17</sup>

Cmdr. Michael McCallion, the site commander from the Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3) testified that he was still working with the possibility in mind that it was a rescue. Before the victims were removed, he met with the HUSAR/TF3 doctor and Dr. Bradford and explained the planned approach. First, he would have a HUSAR/TF3 paramedic assess whether the victim was dead or alive: "Not pronounced dead, but considered dead." HUSAR/TF3 had made arrangements, through its doctor, to ensure that the necessary supplies were in place to treat the victims, including treatment for crush injuries. If the victim was considered deceased, the coroner would be called in to do whatever work he considered necessary before the victim was removed from the pile. This process occurred for both Mrs. Perizzolo and Ms. Aylwin, when their bodies were accessible.<sup>18</sup> The rescue workers were at least prepared for the possibility of survival.

Capt. Tony Comella, the team coordinator for HUSAR/TF3, was asked why the rescue workers did not focus first on recovering Ms. Aylwin's body. His answer was somewhat equivocal. He initially suggested that the rescue workers may not have gone directly to the area where Ms. Aylwin was located because the dog searches had shown no signs of life. He then added that the approach taken, starting first with the removal of debris above Mrs. Perizzolo, was the safest and fastest way to proceed:

Q. And I'm just wondering why – if you knew – if you had a general idea where the person who might be alive was, why weren't the efforts focused – going to that area and going through that and seeing if she was still alive?

A. I believe that was based on our dog search showing no signs of life. However, we didn't really – the identification of somebody underneath the debris is often plus-minus several feet. So we had a way to systematically remove debris without hurting anybody. It seemed like a solid plan ... to work into the pile that way. I don't think ... it would have been any faster regardless of the method we used at that point.<sup>19</sup>

I found this second justification from Capt. Comella to be confusing. During the slinging process using the Millennium crane, I had heard evidence that rescue workers directed their efforts to slinging and removing the slabs directly above where they believed the live victim (later confirmed to be Ms. Aylwin) was located, and that they were making progress toward reaching her.<sup>20</sup>

Although I need not conclude with certainty, I suspect the real reason for proceeding from the outside in was to place the emphasis on the safety and preservation of the bodies of the deceased victims. Capt. Comella gave this justification first, and I consider it the most likely one. Although I recognize that certain provisions were made for the possibility of survival, I am of the opinion that, if the rescue workers had truly believed in the possibility that Ms. Aylwin was alive at this stage, they would have used more aggressive and determined methods to go straight to her location to remove her. However, the fact of the matter is that, on June 27, the rescue workers had two cadaver dog hits indicating two deceased persons. I conclude that those in charge of the operation at this stage did not actively seek out a way to immediately remove the debris above Ms. Aylwin because the evidence indicated she was already dead. They opted instead for the safest approach and the one that would preserve the integrity of the bodies to the greatest extent possible.<sup>21</sup>

## **Mrs. Perizzolo's body is removed from the rubble shortly after 9:15 a.m. on June 27**

Cst. Burns's notes indicate that, at 8:40 a.m., a member of UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) went to the identification station and advised that they were ready for Dr. Bradford to attend. Dr. Bradford was able to approach Mrs. Perizzolo's body. A number of recovery workers were on the pile at the time, and she was still largely covered by debris, although not by any slabs. Dr. Bradford said he was "barely" able to see her body, her hand, and her foot. Because further removal of debris was necessary in order to properly examine the body, Dr. Bradford and Cst. Burns returned to the identification tent to wait.<sup>22</sup> Dr. Bradford was able, at that time, to pronounce the victim deceased.<sup>23</sup>

Dr. Bradford returned to the body at 9:14 a.m. Debris removal had progressed, and he was better able, at that time, to observe the body and its injuries, which I discuss later in the Report. He was satisfied, on the basis of a family photo he had in his possession, that the victim was Mrs. Perizzolo.<sup>24</sup>

Mrs. Perizzolo's family was notified immediately. Darrin Latulippe, Mrs. Perizzolo's son-in-law, told the Commission that he and his wife, Teresa Perizzolo, had been informed that Mrs. Perizzolo's body had been found at about 9:15 a.m. on June 27. They were shown some of her personal effects, including a chain and cross they recognized immediately. They were not offered the opportunity to be present when Doloris Perizzolo was removed from the rubble, but said they would not have wanted it.<sup>25</sup>

Mrs. Perizzolo's body was removed from the rubble shortly after 9:15 a.m.<sup>26</sup>

Chief Paul Officer, the incident commander from the Elliot Lake Fire Department, and Staff Insp. Needles arranged to have two people from each of UCRT, HUSAR/TF3, and the Elliot Lake Fire Department remove Mrs. Perizzolo's body. The same process would be followed with Ms. Aylwin. The hope was that this inclusive process would provide closure for the rescue workers.<sup>27</sup>

## **Ms. Aylwin's body is removed from the rubble at approximately 1 p.m.**

A significant amount of work remained before the rescue workers were able to remove Ms. Aylwin's body from the rubble. Mr. Priestly suggested there was something in the order of 40 tons of debris yet to be removed. Some of the delay was to allow the coroner to take pictures of the first victim.<sup>28</sup> The remaining delay appears to have been due to the volume of material overlying her body.

The rescue workers were still having difficulty pinpointing the exact location of Ms. Aylwin's body. Dogs were used to narrow the focus.<sup>29</sup> The OPP's Cst. Ryan Cox took Fuse back onto the pile at some point following removal of Mrs. Perizzolo's body and before 12 noon.\* His notes, which do not provide any times, state that Fuse showed interest where Mrs. Perizzolo's body had been located and at a spot in the middle of the pile:

.....

\* Cox testimony, August 26, 2013, pp. 22414–18. Cst. Cox did not give time indications in his notes, but does indicate that Cst. Bailey ran a search with Charlie and Dare after his search with Fuse. Cst. Bailey indicated in his notes that he began his search at 12:20 p.m. on June 27. Hence the conclusion that Cst. Cox's search with Fuse occurred after Mrs. Perizzolo's body was removed (as his notes indicate) and before Cst. Bailey's search at 12:20 p.m.



Advised 1st body removed from east wall – Cadaver dog search requested PSD Fuse conducted search and he indicated on a spot near a garbage can lid which was close to east wall near where 1st body recovered from and a spot in the middle of pile – he didn't sit but showed great interest in these two spots – I could not detect any odour myself – Bailey ran PSD's Charlie & Dare after me, I was advised they both hit same spots.<sup>30</sup>

As Cst. Cox's notes indicate, Cst. Bailey also put Charlie and Dare on the pile after Cst. Cox and Fuse. According to Cst. Bailey's notes, his search, first with Charlie, then with Dare, occurred at around 12:20 p.m.<sup>31</sup> Charlie and Dare both showed interest in the same spots as Fuse.<sup>32</sup> All three dogs showed interest but did not sit. Sitting would have been the clearest indication of the presence of a deceased person at that location. Cst. Bailey explained that the lack of certainty may have related to the previous movement and compression of debris. Both Cst. Cox and Cst. Bailey advised the rescue workers where to concentrate their efforts.<sup>33</sup>

At about 12:30 p.m., around the same time that Cst. Bailey was conducting his searches with Charlie and Dare, Dr. Bradford contacted Ms. Aylwin's parents.<sup>34</sup> Ms. Aylwin had not yet been uncovered, but Dr. Bradford was looking for a photograph to assist with the identification process.<sup>35</sup>

Ms. Aylwin's body was found almost due west of where Mrs. Perizzolo's body had been found.<sup>36</sup> OPP Cst. Steve Hulsman was the first to spot her during the removal of debris. He called a stoppage, and on closer inspection realized he had seen Ms. Aylwin's hip and the small of her back. Discussion ensued on how to remove the concrete slabs on top of her without causing damage to the body. The removal was eventually done using cribbing, small lifts, and chains. Small pieces of 4x4 wood were placed underneath the slabs until chains could be placed all around the slabs in a manner allowing for full lift-off, using Priestly's hydraulic equipment.<sup>37</sup>

This process of removing the slabs directly on top of Ms. Aylwin had not begun when, at 12:55 p.m., Dr. Bradford was summoned to the site. Ms. Aylwin's body had been mostly uncovered. She was visible, with the exception of the two large slabs of concrete sitting on top of her and debris scattered around and above her. Rescue workers were still on the pile. Ms. Aylwin is referred to as "deceased" in Cst. Burns's notes.<sup>38</sup>

Photographs showing the position of debris and two slabs on top of Ms. Aylwin's body were taken shortly after 1 p.m. on June 27. The top slab appears broken in two. Other photos illustrate the process of slab removal, using chains and the Priestly equipment.<sup>39</sup> Out of respect for Ms. Aylwin's family, I refrain from reproducing these photos. This written narrative is sufficient, and nothing is gained by their inclusion.

At 1:33 p.m., using chains and the Priestly equipment, the rescue workers were able to pull the slabs off Ms. Aylwin. Her body could now be removed.<sup>40</sup>

Cst. Burns's notes indicate that Ms. Aylwin was removed from the site at 1:34 p.m. on June 27 and taken to the identification tent.<sup>41</sup> As with Mrs. Perizzolo, Ms. Aylwin's stretcher was carried by two representatives each from the Elliot Lake Fire Department, UCRT, and HUSAR/TF3.<sup>42</sup> Dr. Bradford used a photograph provided by Ms. Aylwin's father to satisfy himself of her identity.<sup>43</sup>

Gary Gendron, Ms. Aylwin's fiancé, was informed that Ms. Aylwin's body had been found, although he could not remember who spoke to him. He recalled that the families were brought to the OPP station. He was given the opportunity to go to the site itself, and he did so.<sup>44</sup>

Shortly after 2 p.m., the bodies of Mrs. Perizzolo and Ms. Aylwin were released to a funeral services company for transport to the hospital in Sudbury.<sup>45</sup>

## Rescue workers conducted a final search of the pile, and Chief Officer turned command over to the OPP

The rescue workers searched and used dogs on the remainder of the pile to ensure there were no other victims. None were found.<sup>46</sup>

Sgt. Gillespie's recollection was that the search of the rubble ended around 4 p.m. on June 27. He testified that he and others had been awake since 9 a.m. the day before and desperately needed sleep.<sup>47</sup> He was not the only witness to admit to sheer exhaustion. Staff Insp. Neadles estimated that he slept four out of every 24 hours during the time he spent in Elliot Lake, and he agreed that Cmdr. McCallion and Capt. Comella were equally sleep deprived.<sup>48</sup>

Chief Officer terminated his incident command at 6:34 p.m. on June 27. He turned the scene over to OPP Incident Commander Kevin Webb.<sup>49</sup>

## The premier visits Elliot Lake

In the early afternoon on June 27, Premier McGuinty learned that the bodies of Mrs. Perizzolo and Ms. Aylwin had been recovered. He arrived in Elliot Lake later that day.<sup>50</sup>

One of the first things the premier did was to meet with close family of the victims. He attended a meeting at the OPP detachment, where some of the family members were present. He was accompanied by Madeleine Meilleur (minister of community safety and correctional services, MCSCS), Ian Davidson (deputy minister, MCSCS), Commissioner Dan Hefkey, and John O'Leary (manager of legislative issues in the Premier's Office). The meeting lasted about an hour. One of the family members was distraught about the rescue having been shut down on June 25, and Mayor Richard Hamilton, who was present, took the brunt of much criticism.<sup>51</sup>

After meeting with the families, Premier McGuinty met with some of the rescue workers. He shook hands and thanked them.<sup>52</sup> The UCRT team left before they could meet the premier because they were simply too exhausted to wait.<sup>53</sup>

Premier McGuinty then made himself available to the media and provided a statement that included the following passage, indicating that he felt something needed to be done to address the lessons learned from this tragedy:

Today, as you've heard, we recovered the bodies of Dolores [*sic*] and Lucie. And we all know we were going to do everything we could to return them to their families where they belong. We owe that to the families. We owe that to all the people of Elliot Lake.

And there's something else we all owe each other. We need to carefully review how we responded to this tragedy. My undertaking to you and to all Ontarians is we will learn any lessons there are to be found here. Ontarians are committed to having in place at all times a world-class emergency response system.<sup>54</sup>

Following the meeting with the media, Premier McGuinty went to thank volunteers, including those involved in preparing meals for people from out of town. Someone in the community even allowed him to sleep in their home because no rooms were available in Elliot Lake at the time.<sup>55</sup> The next day the premier met with the mayor, City representatives, and people from the business community in order to address the medium-term economic issues Elliot Lake would be facing as a result of the collapse.<sup>56</sup>

## Notes

- <sup>1</sup> Bailey testimony, August 27, 2013, pp. 22795–6; Exhibit 6374, pp. 007–009.
- <sup>2</sup> Priestly testimony, October 2, 2013, pp. 27898–9; Exhibit 6622; Gillespie testimony, September 3, 2013, p. 23778.
- <sup>3</sup> Bailey testimony, August 27, 2013, pp. 22796–9; Exhibit 6374, pp. 008–009.
- <sup>4</sup> Bailey testimony, August 27, 2013, pp. 22798–801.
- <sup>5</sup> Bradford testimony, August 29, 2013, pp. 23156–7; Exhibit 6404, p. 025.
- <sup>6</sup> Bradford testimony, August 29, 2013, pp. 23142–6.
- <sup>7</sup> Bradford testimony, August 29, 2013, pp. 23157–8; Exhibit 6404, p. 025.
- <sup>8</sup> Bradford testimony, August 29, 2013, p. 23158.
- <sup>9</sup> Bradford testimony, August 29, 2013, pp. 23158–61.
- <sup>10</sup> Bradford testimony, August 29, 2013, pp. 23161–4; Exhibit 6404, p. 025.
- <sup>11</sup> Priestly testimony, October 2, 2013, pp. 27906–7.
- <sup>12</sup> Priestly testimony, October 2, 2013, pp. 27904–6.
- <sup>13</sup> Priestly testimony, October 2, 2013, pp. 27905–7.
- <sup>14</sup> Priestly testimony, October 2, 2013, p. 27908.
- <sup>15</sup> Priestly testimony, October 2, 2013, pp. 27910–11.
- <sup>16</sup> Priestly testimony, October 2, 2013, pp. 27908–10.
- <sup>17</sup> Exhibit 7477, p. 156; Neadles testimony, September 12, 2013, p. 25641.
- <sup>18</sup> McCallion testimony, September 6, 2013, pp. 24656–62.
- <sup>19</sup> Comella testimony, September 5, 2013, pp. 24312–13.
- <sup>20</sup> Comella testimony, September 5, 2013, pp. 24313–14.
- <sup>21</sup> Waddick testimony, August 23, 2013, pp. 22040–3 and 22086–8; McCallion testimony, September 6, 2013, pp. 24654–5.
- <sup>22</sup> Bradford testimony, August 29, 2013, pp. 23166–71; Exhibit 6404, p. 029.
- <sup>23</sup> Bradford testimony, August 29, 2013, pp. 23172–4; Exhibit 9237.
- <sup>24</sup> Bradford testimony, August 29, 2013, pp. 23171 and 23177–8; Exhibit 6404, p. 029.
- <sup>25</sup> Latulippe and Perizzolo testimony, August 7, 2013, pp. 19932–3.
- <sup>26</sup> Exhibit 7477; Exhibit 6622; Priestly testimony, October 2, 2013, p. 27910.
- <sup>27</sup> Officer testimony, August 22, 2013, pp. 21862–3; Thomas testimony, August 20, 2013, p. 21161; Neadles testimony, September 12, 2013, pp. 25649–50.
- <sup>28</sup> Priestly testimony, October 2, 2013, pp. 27911–12; Exhibit 6404, p. 031.
- <sup>29</sup> McCallion testimony, September 6, 2013, p. 24662.
- <sup>30</sup> Exhibit 6377, p. 010.
- <sup>31</sup> Bailey testimony, August 27, 2013, p. 22802; Exhibit 6374, p. 011.
- <sup>32</sup> Exhibit 6377, p. 10; Bailey testimony, August 27, 2013, pp. 22804–5.
- <sup>33</sup> Bailey testimony, August 27, 2013, pp. 22805–10; Exhibit 6374, p. 011; Cox testimony, August 26, 2013, p. 22418.
- <sup>34</sup> Exhibit 9254.
- <sup>35</sup> Bradford testimony, August 29, 2013, pp. 23180–1.
- <sup>36</sup> Exhibit 6404, p. 034.
- <sup>37</sup> Hulsman testimony, August 28, 2013, pp. 23079–82.
- <sup>38</sup> Exhibit 6404, p. 033; Bradford testimony, August 29, 2013, pp. 23181–3.
- <sup>39</sup> Bradford testimony, August 29, 2013, pp. 23186–8.
- <sup>40</sup> Exhibit 6404, p. 034; Bradford testimony, August 29, 2013, pp. 23188–9.
- <sup>41</sup> Exhibit 6404, pp. 034–035; Bradford testimony, August 29, 2013, pp. 23195–8.
- <sup>42</sup> Officer testimony, August 22, 2013, pp. 21862–3; Thomas testimony, August 20, 2013, p. 21161; Neadles testimony, September 12, 2013, pp. 25649–50.
- <sup>43</sup> Exhibit 6404, pp. 034–035; Bradford testimony, August 29, 2013, pp. 23195–8.
- <sup>44</sup> Gendron testimony, August 8, 2013, pp. 20045–50.
- <sup>45</sup> Bradford testimony, August 29, 2013, p. 23179; Exhibit 6404, p. 035.
- <sup>46</sup> Priestly testimony, October 2, 2013, p. 27912; Hulsman testimony, August 28, 2013, p. 23082; Fowlds testimony, September 19, 2013, pp. 26360–1.
- <sup>47</sup> Gillespie testimony, September 3, 2013, pp. 23794–8; Waddick testimony, August 23, 2013, p. 22045.
- <sup>48</sup> Neadles testimony, September 12, 2013, pp. 25642–3.
- <sup>49</sup> Officer testimony, August 22, 2013, p. 21863; Exhibit 8025, p. 7.
- <sup>50</sup> McGuinty testimony, October 9, 2013, pp. 28955–6.
- <sup>51</sup> McGuinty testimony, October 9, 2013, pp. 28956–9; Latulippe testimony, August 7, 2013, pp. 19934–6; Réjean Aylwin testimony, August 7, 2013, pp. 19989–91.
- <sup>52</sup> McGuinty testimony, October 9, 2013, pp. 28959–63.
- <sup>53</sup> Gillespie testimony, September 3, 2013, pp. 23795–6.
- <sup>54</sup> McGuinty testimony, October 9, 2013, pp. 28959–63; Exhibit 8979.
- <sup>55</sup> McGuinty testimony, October 9, 2013, p. 28964.
- <sup>56</sup> McGuinty testimony, October 9, 2013, pp. 28964–7.





## The Victims: Cause and Time of Death

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## Introduction

Tragically, two people died as a result of the collapse of the Mall.

Doloris Perizzolo was 74 years old at the time of her death. She was born in Kirkland Lake, Ontario. She moved with her parents to Serpent River, Ontario, and then, in 1957, to Elliot Lake. She had three daughters and a son. She worked as a waitress and then, for 22 years, as a cook in the kitchen at St. Joseph's Hospital. She retired in 1994. Her husband, Giuseppe "Joe" Perizzolo, died on May 22, 2011. She is survived by her daughters Teresa Perizzolo of Elliot Lake, Cindy Lee Allan of Guelph, and Roberta Rayburn of Hamilton, and was predeceased by her son, Norman.<sup>1</sup>

Lucie Aylwin was born on March 28, 1975, and moved to Elliot Lake with her parents when she was a year-and-a-half old. She lived her entire life in Elliot Lake. She worked for Collège Boréal as an employment counsellor and part-time at the ticket kiosk in the Mall. She is survived by her parents, Rachelle Aylwin and Réjean Aylwin, her younger brother, Stéphane, and her fiancé, Gary Gendron.<sup>2</sup>

Although it appears very clear that Doloris Perizzolo died almost instantly after the collapse, the evidence does not allow as certain a conclusion about Lucie Aylwin. She probably lived for some time after the initial collapse.

## Doloris Perizzolo

Capt. John Thomas of the Elliot Lake Fire Department found Mrs. Perizzolo's body at 4:30 p.m. on June 23. He could see a hand and foot extending from the rubble. He checked her wrist. It was cold to the touch, and there was no pulse. He asked the paramedics to confirm that there were no vital signs, and they did.<sup>3</sup>

Dr. Marc Bradford, the coroner, was at the Mall at 8:40 a.m. on June 27. He was shown Mrs. Perizzolo's body close to the wall of the Mall, near some pay phones. Debris was leaning against her, and some concrete was beside the debris. Dr. Bradford made the formal pronouncement of death at the scene of the collapse, before Mrs. Perizzolo's body had been removed, at 8:45 a.m. on June 27.<sup>4</sup> More debris was removed, and Dr. Bradford returned to the site at 9:14 a.m. He noticed an obvious ankle fracture that Mrs. Perizzolo had suffered. Although he could not determine the cause of her death at that time, he testified that he was "very suspicious that trauma was involved" – that she had been struck by a large amount of debris.

The bodies of both Mrs. Perizzolo and Ms. Aylwin were sent on June 27 to Dr. Martin Queen, a forensic pathologist, at Health Sciences North in Sudbury. Dr. Queen received his medical degree from the University of Toronto in 1981 and practised as a family physician in Toronto and Nova Scotia before returning to Toronto in 1988 to begin training as a pathologist. He studied at a number of hospitals in Toronto and, in 1992, received a fellowship from the Royal College of Physicians and Surgeons in anatomical pathology and became a diplomate of the American Board of Pathology in anatomical pathology. "Anatomical pathologists" generally analyze specimens and tissues from live patients, in order to aid in diagnoses. Forensic pathology is a subspecialty that deals with the investigation of deaths. Forensic pathologists perform autopsies and post-mortem examinations to determine the cause of death.<sup>5</sup>

Dr. Queen worked as an anatomical pathologist in Toronto until 1995, when he received a fellowship in forensic pathology at the Office of the Chief Medical Examiner in Baltimore, Maryland. In 1996, he became a diplomate of the American Board of Pathology in forensic pathology. He worked as a forensic pathologist at the Office of the Chief Coroner for Ontario from 1996 to 1999, and has worked as a forensic pathologist at Health Sciences

North since May 1999. Since 2010, he has been the director of the Northeastern Regional Forensic Pathology Unit in Sudbury. He is also an adjunct professor in the Department of Forensic Science at Laurentian University in Sudbury. Dr. Queen is clearly a highly qualified and experienced forensic pathologist.<sup>6</sup>

Dr. Queen worked into the early hours of June 28 conducting his initial post-mortem examination. At 2:43 a.m., he sent an email to Dr. Michael Pollanen, the chief forensic pathologist for the Province of Ontario, and Dr. Craig Muir, the local regional coroner. He wrote with respect to Mrs. Perizzolo:

Greetings at 2 in the morning. We just finished both cases. Here's what I have so far:

Jane Doe #1 – PERRIZZOLO [*sic*], Doloris, DOB Jan 12, 1938 (74 yo)

- determined to be deceased shortly after the event, scene photos show entrapment under tons of debris
- PM [post-mortem] shows obviously rapidly fatal massive blunt force head injury with vault and basal hinge fractures, brain trauma, carotid artery laceration and exsanguination
- I don't see any obvious reason why her body couldn't be released later today.
- ...
- interestingly neither body showed any signs of decomposition despite an apparent post-mortem interval of 4 days for both.<sup>7</sup>

As the coroner, Dr. Bradford's role is to determine what he called the "five questions": who died, when they died, where they died, how, and by what means – accident, homicide, suicide, or undetermined. In some cases, such as the deaths of Mrs. Perizzolo and Ms. Aylwin, it is necessary for him to obtain assistance from a forensic pathologist.<sup>8</sup>

On June 28 at 4:28 p.m., Dr. Bradford spoke to Mrs. Perizzolo's daughters and told them (as is set out in a contemporaneous email) that their mother's cause of death was massive trauma especially to the head, and that "their mother died almost instantly and didn't suffer."<sup>9</sup>

A coroner is required to issue a report, entitled "The Coroner's Investigation Statement," answering the five questions. Dr. Bradford issued a preliminary report dated October 31, 2012. At that time, Dr. Queen had not yet produced a formal autopsy report, and all that Dr. Bradford had received from him was the email of June 28 and information in a subsequent telephone conversation.<sup>10</sup> Dr. Bradford wrote:

Dr. Queen performed a very thorough autopsy that demonstrated massive blunt trauma including massive trauma to her head and a carotid artery laceration.

Given the evident debris overlying Mrs. Perizzolo, as well as the severity of her injuries found at autopsy the strong balance of probability favours massive blunt trauma as a cause of death that occurred almost instantly at the time of the rood [*sic*] collapse on June 23, 2012.<sup>11</sup>

Dr. Bradford was asked during his testimony to be more precise about the time of death than he had seen in that report. He testified that he would defer to Dr. Queen for a more accurate answer, but that he believed that the chance of Mrs. Perizzolo surviving 20 minutes was less than her surviving 10 minutes, and greater than her surviving one hour.<sup>12</sup>

Dr. Queen's autopsy report for Mrs. Perizzolo, dated December 4, 2012, noted a number of injuries, of which the most specific was described by him as a "hinge fracture through middle cranial fossae [the cavity in the skull which houses the temporal lobes of the brain], L>R, with laceration of left carotid artery, decreased intravascular blood volume and absent post mortem lividity." Dr. Queen testified that the injury he described was the result

of application of blunt force at the base of the skull under the brain. This injury lacerated the left carotid artery, which is one of the two main arteries pumping blood from the heart into the brain. This laceration would have produced, as Dr. Queen testified, “massive instant bleeding.” The blood loss would have been so great that there was no “lividity,” the marking or bruising of the body at its lowest point, caused by the gravitational settling of the blood in the deceased person.<sup>13</sup>

Dr. Queen’s autopsy report also described severe fractures to the ribs, from the top of the chest to about two-thirds of the way down the chest and a fracture high up in the lumbar spine (slightly above the navel), which was caused by pressure rather than a bending of the spine. Mrs. Perizzolo also suffered fractures to her pelvis and her ankle. The report concluded:

At postmortem examination there were both definitively and additional potentially fatal blunt force injuries. Most proximate to the death was a severe fracture through the base of the skull with tearing of the left carotid artery.

The resulting mechanism of death was rapid exsanguination [loss of blood]. This injury is not survivable and death would have been inevitable and near-immediate.<sup>14</sup>

Dr. Queen testified that Mrs. Perizzolo would have been unconscious immediately and dead within a few minutes of her injuries.<sup>15</sup>

I accept Dr. Queen’s opinion. It is clear to me that Mrs. Perizzolo died, as he put it, almost immediately after the Mall collapse, which caused her significant injuries. The medical evidence is unequivocal. It is corroborated by the signs noted by Capt. Thomas two hours after the collapse. Mrs. Perizzolo’s death was a tragedy. It may be a small mercy that it was quick.

**Mrs. Perizzolo’s death was a tragedy. It may be a small mercy that it was quick.**

## Lucie Aylwin

Dr. Bradford and Cst. Dale Burns, the OPP photographer, entered the area of the rubble pile where Ms. Aylwin’s body was located at approximately 1 p.m. on June 27. Dr. Bradford testified that there was a large slab of concrete lying on top of Ms. Aylwin, with debris scattered around her body. He marked the location of her body on a photograph taken at 1:06 p.m. It appears, from viewing the photograph, to be several feet west of the area where Mrs. Perizzolo was located.<sup>16</sup>

After the debris had been lifted from Ms. Aylwin, Dr. Bradford was able to see that she was surrounded by a scattering of lottery tickets and that she was curled up on her left-hand side, with her hands curled in front of her, very close to her face, approximately on her chin, just below her mouth. He noted that there was a space around her face, and it was not completely covered in crumbled material or dust bits. He concluded, as a result of this observation, that she had been located in a “void.”<sup>17</sup>

Dr. Bradford checked to see if there was any evidence from the scene that Ms. Aylwin had struggled to escape, but he found none. He noted that the scene had been so disturbed that any such marks may have been obliterated. He observed that Ms. Aylwin had some trauma to her nose, some edema (swelling) about her face, and a large laceration of her left knee. He suspected that her death was caused by what he described as a “massive trauma” – being hit by a large amount of debris.<sup>18</sup>



## Physicians' initial opinions as to time of death: probably very quick, but not certain

Dr. Queen's email to Dr. Pollanen and Dr. Muir, sent at 2:43 a.m. on June 28, after he completed his initial post-mortem review, had the following comments about Ms. Aylwin:

- scene photos also show entrapment under tons of debris.
- PM shows no definitive fatal injury, however severe posterior rib fracturing, anterior chest wall hemorrhage and florid conjunctival, facial, peri-orbital and oral mucosal petechiae strongly support a diagnosis of asphyxia due to chest compression.
- despite the media reports of possible "signs of life" up to 48 hours after the collapse, I am highly skeptical and believe that this victim also died very quickly (her fingernails are totally intact and very clean showing no evidence of [having] tried to "claw her way out").
- some pending studies include 1) microscopic examination of some of the skin injuries and rib #'s to r/o [rule out] a vital reaction; 2) histology of the lungs to rule out fat emboli; 3) histology of the kidneys to r/o rhabdomyolysis [sic]; 4) vitreous chemistry to r/o dehydration and/or renal failure, I don't think I will find any of these things.
- ...
- interestingly neither body showed any signs of decomposition despite an apparent post-mortem interval of 4 days for both.<sup>19</sup>

At approximately 8 p.m. on June 28, Dr. Bradford spoke with Réjean Aylwin, Ms. Aylwin's father, and told him that his daughter's death had been caused by crush injuries to her chest so that her death was "quick." He said that they did not know when she had died and some investigations were still pending. Mr. Aylwin, who had spent his working life in underground mines, asked whether his daughter had died after some of the structure moved following a few days of survival.<sup>20</sup>

Dr. Bradford's preliminary report, prepared October 31, 2012, with respect to Ms. Aylwin, stated:

Dr. Queen performed an autopsy that found severe posterior rib fractures and facial and oral petechiae implying asphyxia as the cause of death. Given the amount of debris at the scene and the autopsy findings the balance of probabilities strongly favours that Ms. Aylwin expired very rapidly after the collapse.<sup>21</sup>

Dr. Bradford's final report, however, prepared after he reviewed Dr. Queen's autopsy report of December 4, 2012 (which I will describe below), was not so categorical. It stated:

An autopsy, in conjunction with radiological investigations, revealed evidence of severe fracturing of thoracic vertebrae and multiple posterior ribs in addition to stigmata of asphyxia. The cause of death was concluded to be crush asphyxia by the forensic pathologist. Consideration of the scene circumstances and analysis of anatomic, histologic, neurologic and biochemical evidence did not support any significant post-injury survival time.<sup>22</sup>

When asked to explain the difference in language between the two reports, Dr. Bradford testified: "[T]o be blunt, I was being more careful." It was his evidence that he did not know when the crushing injury which caused Ms. Aylwin's death occurred. He testified that it was possible "but very unlikely" that she had sustained some injury as a result of the collapse, found herself in a void, and was crushed later by a subsequent shift of the debris under which she was located. He explained that he thought this possibility very unlikely because he relied on Dr. Queen's report for his conclusions, and Dr. Queen described the injuries as occurring all at the same time. He acknowledged, however, that it is possible that she sustained some crush injury at the time of the collapse which would not have caused her death right away, and then survived for a period of time.<sup>23</sup>

## Palms in a wet environment

Dr. Queen's autopsy report for Ms. Aylwin, dated December 4, 2012, noted that there was wrinkling on both of her palms. Dr. Queen testified that wrinkling is typically seen in a wet environment, such as when someone has been pulled from a bathtub or a swimming pool or other very wet environment, and is sometimes called "washer woman's hands."<sup>24</sup>

## Severe fracture of thoracic vertebrae – not the cause of death

The report also noted that Ms. Aylwin had suffered a "severely comminuted and displaced Chance type fracture at T8 and T9." A comminuted fracture means that the bone has fractured into multiple fragments, and a displaced fracture means that the bone is not in its normal location. "T8" and "T9" refer to the eighth and ninth thoracic vertebrae, located on the back of the chest, below the neck and above the lumbar area. Dr. Queen explained that a Chance fracture (named after Dr. G.Q. Chance, the first physician to describe it) is a compression injury to the front and a transverse fracture through the back. It occurs when someone is forced to suddenly bend forward in a violent way, fracturing the backbone. This action causes the front part of the vertebral bodies to get compressed, and the back part to fracture. It was most often seen in motor vehicle collisions when passengers wore only a lap belt and not a chest belt, so that when a car struck an object in front of it, the passengers would be flexed forward with their hips restrained by the belt.<sup>25</sup>

Dr. Queen testified that the Chance fracture did not cause Ms. Aylwin's death and does not tell us anything about the time of her death. He also testified that he thought it likely that the fracture happened when she was standing at the ticket kiosk in the Mall and struck by concrete from the original collapse, causing her to flex forward. He volunteered, however, that if after she was trapped her upper body still had some room for movement, and if there was some kind of secondary shift or smaller collapse, it was possible that the Chance fracture occurred at that time.<sup>26</sup>

## Lacerations to left knee and right shin – no more than a little longer than three hours before death, and more than minutes or a few hours before the body was recovered

Dr. Queen noted a deep laceration of Ms. Aylwin's left knee and a laceration of her right shin. Analysis of skin and subcutaneous tissue taken from those areas showed that the blood cells had not yet begun to break down. Dr. Queen testified that blood cell breakdown begins between 12 and 48 hours after an injury if the victim is still alive.<sup>27</sup> Consequently, the injuries to the left knee and right shin would have occurred at the time of, or up to 48 hours before, Ms. Aylwin's death. Had she survived for longer than that period of time, there should have been an indication of blood cell breakdown.

The microscopic analysis of the skin and tissue also showed no inflammatory or reparative reaction. Dr. Queen explained that the body will react to an injury by sending in white blood cells as long as the person is still alive. When asked how long after an injury it would be before such a reaction can be seen, he testified that it could not "be quantified in an exact way because there are so many variables, and there are so many unknowns." In some cases, some changes in the white blood cells are seen as early as 30 minutes after an injury, although most cases take somewhat longer – perhaps three hours or "possibly a little longer." The fact that no such reaction had occurred here led him to conclude that Ms. Aylwin did not live a long time after the knee and shin injuries – perhaps a little longer than three hours at most.<sup>28</sup>

The analysis of the samples from the left knee and right shin laceration also showed “well-established cutaneous and subcutaneous [at and below the skin] postmortem [after death] bacterial overgrowth.” Dr. Queen explained that, very shortly after death, bacteria escapes from the body and multiplies, often quite rapidly. He testified that he could not quantify how long it would take for bacterial growth of the type seen at the site of the lacerations to Ms. Aylwin’s knees and shin, other than to say that she died earlier than “minutes or a few hours before her body was recovered.”<sup>29</sup>

Ms. Aylwin also suffered fractures of a number of her ribs. Analysis of cell samples from the fractures of her right seventh and eighth ribs showed, as with the knee and shin lacerations, no red blood cell breakdown and no inflammatory or reparative reaction. Bacterial overgrowth like that seen on the knee and shin lacerations was not found, but Dr. Queen explained that this area was more protected from bacterial contamination.<sup>30</sup>

I note, however, that, like the Chance fracture, these findings are not determinative of the time of Ms. Aylwin’s death. The left knee and right shin lacerations and the rib fractures could have occurred well after the initial collapse if there had been a secondary shift or smaller collapse that had caused the Chance fracture and/or those injuries. If so, she could have died within a few hours of those injuries and more than a few hours before her body was recovered. If that had happened, the blood cells would not have begun to break down, the reparative reaction would not have begun, and the bacterial growth could have begun.

### **Hands cupped in front of her face, catching blood from above**

A photograph taken of Ms. Aylwin on June 27 at 1:33 p.m., before her body was moved, shows her semi-prone, facing down on her left side, with her knees bent at almost 120 degrees to her thighs, and her abdomen bent forward at an angle of approximately 135 degrees to her thighs. Her elbows are bent with her forearms pushed up tight against her face. Dr. Queen testified that the photograph was consistent with her hands being in front of her face at the time she was put in that position.<sup>31</sup> This statement accords with Dr. Bradford’s description of Ms. Aylwin at the scene before her body was moved – her hands were curled in front of her face, just below her mouth, with a space around her face.

The notes Dr. Queen made when he initially examined Ms. Aylwin’s body described no lacerations on her right hand. A photograph taken shortly after her recovery showed blood on her right hand. Dr. Queen testified that that blood was not from cuts to her right hand, because it washed off. It was from a different source. Dr. Queen testified that the blood on her right hand was consistent with the blood from her nose having leaked onto her hand if the right hand was close to the lower portion of her face. The same photograph shows significant bleeding from Ms. Aylwin’s nose. A close-up photograph of her hands taken at 1:43 p.m. on June 27, just less than 10 minutes after she was removed from the scene, shows that the blood on her right hand was wet. Dr. Queen described the blood as “relatively fresh.”<sup>32</sup>

A photograph taken June 27 at 10:02 p.m. shows a significant abrasion or laceration on the right side of Ms. Aylwin’s forehead extending from halfway across her right eyebrow back below the hairline, measured by Dr. Queen to be 9 centimetres long by 3 centimetres wide. Dr. Queen took no cellular sample from this injury. He testified that he did not know whether this injury occurred at the same time as the injuries to the shin, knees, and ribs.<sup>33</sup>

I conclude that, after the collapse, Ms. Aylwin had her hands cupped in front of her face and that blood from her nose and, potentially, from the laceration on the right side of her forehead, leaked onto her right hand.



## Cause of death: crush asphyxia

Dr. Queen noted that he observed, as “indicators of asphyxia,” “florid periorbital and facial petechial hemorrhages” and “florid bilateral subconjunctival petechial hemorrhages.” He explained that asphyxia in its broadest terms means lack of oxygen, which could be caused by many things. Petechiae are tiny red spots caused by the bursting of very small blood vessels – minor hemorrhages. They can be seen in many different situations and are thus “nonspecific,” but are one of the indicators of asphyxia. “Periorbital” is the area around the eyes, and “florid” means that the spots were prominent. The conjunctiva is the thin layer on the surface of the eyeball, and “subconjunctival” means the area underneath that layer. These entries in Dr. Queen’s autopsy report thus indicated that these small blood vessels had burst in an obvious way in the area in and around the eyes. He also noted edema, or swelling, around the eyes, and some petechiae on the inside lining of the mouth.<sup>34</sup>

Dr. Queen noted that Ms. Aylwin’s nose was blocked by blood, mucus, and debris. This blockage could have contributed to asphyxia. He found generalized congestion, or excessive fluid, in the organs and tissues, which tends to be prominent in crush asphyxia.<sup>35</sup>

Dr. Queen concluded in his autopsy report that the cause of Ms. Aylwin’s death was “crush asphyxia.” He wrote:

Postmortem examination showed significant blunt force / crush injury to the posterior chest, including severe fracturing of thoracic vertebrae and multiple posterior ribs. Along with less severe blunt force / crushing injury to the anterior chest and florid stigmata of asphyxia, this constellation of findings is typical of death due to “crush asphyxia” (also known as compressive or traumatic asphyxia and Perthe’s syndrome). The findings in this specific case are most consistent with the deceased terminating in a more or less prone position.

Mechanisms of death in crush asphyxia include prevention of breathing movements and mechanical limitation of lung expansion as a result of active chest compression and rapid increase in intrathoracic pressure such that it exceeds that of venous return. Blood cannot re-enter the chest. In these circumstances, innumerable postcapillary venules burst under hydrostatic pressure, producing the most florid physical signs of raised intravenous pressure.<sup>36</sup>

Dr. Queen explained that he came to this conclusion because Ms. Aylwin suffered a quite significant blunt force or crushing injury to her back, including various lacerations and abrasions and indentations of the skin of her back, and, underneath that, multiple fractures of her spinal column and multiple severe fractures of her ribs at the back. These injuries led him to infer that something blunt very forcefully struck her back and caused her to flex forward, causing a compression or squeezing. Ms. Aylwin would not have been able to move her ribcage, which normally acts as a bellows to bring air in and blow it back out. Without this ability, air cannot move in and out of the lungs. Ms. Aylwin would also not have been able to move her diaphragm, a muscle separating the chest from the abdomen that helps lungs contract and expand to move air in and out. Finally, the increased pressure on her chest would create significantly increased pressure inside the chest. Blood returns to the heart through veins, which are at relatively low pressure and run through the chest. If the pressure inside the chest increases so that it is greater than the pressure of the blood in the veins, the blood cannot return to the heart. Therefore, no blood can flow from the heart out to the rest of the body. The failure of the heart to work increases the pressure in other organs and tissues, causing small blood vessels to burst and others to leak fluid and cause congestion.<sup>37</sup>

## **Dr. Queen's opinion as to time of death: "near-immediate"**

Dr. Queen concluded that Ms. Aylwin's death was "most likely near-immediate, and inevitable after the crushing forces were applied."<sup>38</sup>

Dr. Queen testified that his conclusion that Ms. Aylwin died of crush asphyxia does not assist me, in and of itself, in determining whether the injury that caused her death occurred at the time of the collapse or some time later.<sup>39</sup>

Dr. Queen's autopsy report, immediately preceding its conclusion, set out the factors that did lead him to his conclusion as to the time of death. I will deal with each of them in turn.

## **Clean fingernails, so no escape attempt – but this opinion is not in Dr. Queen's area of expertise**

Dr. Queen wrote:

The fingernails of the deceased were clean with no evidence of fresh damage, suggesting the lack of or inability to mount any attempt to "claw" her way out of the situation.<sup>40</sup>

Dr. Queen testified that this opinion was not based on his credentials as a forensic pathologist. "[F]or me," he said, "that was just sort of common sense." He thought that, for someone in a situation where his or her oxygen supply is diminishing and the person is starting to lose consciousness, it would be a "reflexive thing" to try to claw a way out.<sup>41</sup> I have no reason to disagree with Dr. Queen's common sense opinion, but I am aware that I have not heard contradictory or confirmatory expert evidence on point.

## **No inflammatory or reparative reaction – but this observation does not mean that crush injury occurred at time of collapse**

Dr. Queen wrote:

Microscopic examination of representative skin lacerations and rib fractures shows no evidence of any inflammatory or reparative reaction (which would be expected in the event of a significant survival interval).<sup>42</sup>

Dr. Queen agreed that this observation was based on his evidence of the examination of the samples he took from the left knee, the right shin, and the ribs. As I have indicated, that examination, as explained by Dr. Queen, showed that those injuries probably occurred within approximately three hours of death. He agreed, however, that the crush injury which caused the asphyxia would have "certainly" caused the chest and rib injuries, and that, while the injuries were presumably caused by being struck by some debris, he could not say for sure whether it was the same debris as had caused the Chance fracture. A photograph of Ms. Aylwin taken after the concrete which had been covering her was removed showed that her right shin had been under the slab that had been lying on top of her.<sup>43</sup> If the crush injury had occurred at the same time as her shin, knee, and rib were injured, all that the absence of inflammatory or reparative reaction at those sites can tell us is that those injuries occurred within a few hours of her death. That conclusion does not assist in determining whether those injuries occurred at the time of the original collapse or later.

## **No evidence of survival after traumatic brain injury – but Ms. Aylwin did not suffer a traumatic brain injury**

Dr. Queen wrote:

Separate examination of the brain by a neuropathologist (Dr. S. Graham) shows no evidence of changes that may be seen when there is a survival interval following hypoxic-ischemic or traumatic brain injury (no hypoxic-ischemic encephalopathy or diffuse axonal injury).<sup>44</sup>

He testified that, by this entry, he meant there was no evidence of changes in the brain that might be seen if Ms. Aylwin had suffered those specific types of brain injuries and survived for a period of time. He also testified, however, that Ms. Aylwin did not have those types of brain injuries. (This statement was confirmed by a report from Dr. Silvia Gaytan-Graham, a neuropathologist.) Consequently, as Dr. Queen testified, this conclusion gave him no information that could assist in determining the issue of time of death.<sup>45</sup>

### **No evidence of dehydration or hyperglycemia – but low glucose levels are of no help in determining cause of death, and the time for dehydration to be apparent in body fluids is unknown**

Dr. Queen wrote:

Biochemical analysis of vitreous (eye) fluid shows no evidence for dehydration, hemoconcentration or hyperglycemia (some or all of which would be expected in the event of a significant survival interval, particularly in a diabetic with no fluid intake).<sup>46</sup>

This issue was dealt with at length in Dr. Queen's evidence.

Vitreous fluid is found in the eye. Dr. Queen testified that pathologists consider it, rather than blood, for some tests because blood cells start breaking down shortly after death and the blood becomes contaminated. Vitreous fluid, however, is not cellular and is in a protected environment. It is much less likely to be contaminated after death.<sup>47</sup>

Some of the things tested for by pathologists remain in the same concentration for up to 120 hours after death as before death, among them sodium chloride creatinine and urea nitrogen. Glucose, however, is different. Immediately after death, the glucose level in the vitreous fluid starts to drop. Consequently, a low sugar level in the vitreous fluid cannot be relied on to reach any conclusion about the sugar levels before death. A high sugar level in the vitreous fluid, however, can be used as a basis to conclude that the sugar level was high before death, because it would have been dropping since the time of death.<sup>48</sup>

The analysis of the vitreous fluid showed sodium levels of 129, chloride levels of 105, glucose of less than 1.1, urea nitrogen levels of 5.2, and creatinine levels of 153. The unit of measurement for all those levels is millimoles per litre. Dr. Queen testified that the glucose level was low, which, as explained above, means that it was of no value in determining the time of death.<sup>49</sup>

The sodium and chloride levels were at the lower levels of normal, and the urea nitrogen levels were normal. Dr. Queen testified that these results meant that Ms. Aylwin had not been dehydrated at the time of death. If she had been, the effect would have been to elevate the levels of these substances in a given volume of fluid. Removal of water from a fluid in which substances are present results in an increased concentration of those substances. Dr. Queen testified that, from his review of some of Ms. Aylwin's medical records, he noted that she had suffered from diabetes and been insulin dependent since at least December 1988. She had frequent testing done to measure her sugar control, and the records showed that frequent attempts had been made to adjust her insulin doses. Dr. Queen indicated that Ms. Aylwin was "somewhat of a brittle diabetic" – a patient whose diabetes was not well controlled, and subject to hypo- and hyperglycemia (low and high blood sugar). It was Dr. Queen's evidence that a person with such a condition in the situation of Ms. Aylwin – trapped in the debris, not getting insulin, fluids, or food, and having been subjected to serious injuries – would be under tremendous physiological and psychological stress. He believed that such stress would cause her sugar levels to rise – creating more urine and resulting in dehydration. Because there was no evidence of dehydration, he concluded that Ms. Aylwin's survival time after the collapse was quite limited. When asked how long he would expect it to



take for a loss of bodily water to be reflected in an increased concentration of these substances, he testified that “there’s absolutely no way to quantify that. There [are] just too many variables ... too many unknowns.” He had carried out a detailed literature search in an attempt to locate any research that could assist in answering that question, and he could find nothing.<sup>50</sup>

Dr. Queen testified, however, that if counsel were to suggest some lengthy time periods, he “might be willing to shoot them down.” He then testified that, in his view, it was not possible that Ms. Aylwin could have survived 24 hours after the collapse and that 20 hours was highly unlikely. When asked the basis on which he came to that conclusion, however, he testified that his research had failed to provide any information to assist him with this issue – his evidence was simply based on his “experience and belief.”<sup>51</sup>

As Commissioner Stephen Goudge noted in his *Report of the Inquiry into Pediatric Forensic Pathology in Ontario*, evidence of this sort, which places emphasis on authoritative claims based on personal experience that can seldom be quantified or independently validated, is problematic. He suggested, and I agree, that it would be better if forensic pathologists adopted an approach based on empirical evidence – and its scope and limits – as established in large measure by the peer-reviewed medical literature and other reliable sources.<sup>52</sup> I note that Dr. Queen had attempted to find an evidence-based source for his opinion of the length of time following the collapse Ms. Aylwin could have survived and was unable to do so. I must take that into consideration when assessing the weight which should be given to his unsubstantiated opinion.

### Dr. Queen’s conclusion: death most likely “near-immediate”

Dr. Queen’s opinion is best summarized in his autopsy report, where he wrote:

Combined consideration of the scene / circumstantial information, gross morphological findings, microscopic morphological findings, neuropathological findings and vitreous biochemistry results mitigates the likelihood of any significant post-injury survival time. Death was most likely near-immediate, and inevitable after the crushing forces were applied.<sup>53</sup> [Emphasis added.]

**“Death was most likely near-immediate, and inevitable after the crushing forces were applied.”**

– Dr. Queen

His evidence was that he could not “say 100 per cent for certain” when the crushing forces were applied. He testified that, “looking at the entire case, I think it’s probable that the crushing forces were applied at the time of the original collapse.” His evidence in support of that belief was, he said, set out in the first sentence of the paragraph I have just quoted.<sup>54</sup> He agreed that his language in the last sentence of his conclusion was used advisedly. It can be compared with his language in Mrs. Perizzolo’s autopsy report, where he opined that “death would have been inevitable and near-immediate” [emphasis added]. Dr. Queen agreed that the different language used was an indication that the strength of his conclusion with

respect to the time of Ms. Aylwin’s death was less certain than with respect to the time of Mrs. Perizzolo’s death.<sup>55</sup>

Dr. Queen was taken through each of the reasons set out in the above paragraph for his conclusion about time of death. He testified:

1. The “scene / circumstantial information” referred to photographs and videos that the police supplied to him.<sup>56</sup>
2. The “gross morphological findings” referred to
  - (a) the absence of damage to the fingernails and fingers; and
  - (b) the Chance fracture, which in his opinion most likely occurred while Ms. Aylwin was standing and was struck from behind, most logically at the time of the initial collapse;<sup>57</sup>

3. The “microscopic morphological findings” referred to the analysis which showed that there was no reparative reaction of the cells in the injuries to the right knee, the left shin, and ribs which would have been expected if Ms. Aylwin had survived for a long period of time after those injuries.<sup>58</sup>
4. The “vitreous biochemistry” refers to the sodium, chloride, and urea nitrogen levels, which showed no dehydration after the injury. He would have expected to see dehydration, particularly in a diabetic, if she had lived for a significant period of time after the collapse.<sup>59</sup>

I note, with respect to each of these issues, the following:

1. Dr. Queen testified, at the outset of his evidence about Ms. Aylwin’s death, that his answer to the question “did they [the photographs and videos of the scene] tell you anything about the time of death,” was “no”; he later said, however, that

[i]t set the scene that this was a circumstance where you would expect the mortality rate to be high, so it doesn’t mean that someone can’t survive ... People have survived situations like this, but certainly you’re starting with the impression that a mortality rate here would be high.<sup>60</sup>

Commissioner Goudge warned of the dangers of forensic pathologists using circumstantial evidence and noted that, while it was appropriate to do so to some degree, the pathologist should be careful to ensure that he or she is not, “under the guise of scientific opinion ... simply presenting a conclusion drawn from the circumstantial evidence.”<sup>61</sup> Dr. Queen does not have expertise in the area of survival rate in structural collapses. Since it is clear that persons trapped in structural collapses can and do survive, as I will discuss below, it is not safe, in my view, to conclude from the nature of the collapse that death would have been immediate.

2. Dr. Queen testified that his opinion that there ought to have been damage to the fingernails and fingertips was based on “common sense” and not his credentials as a forensic pathologist. As I have indicated, I have heard no expert evidence affirming or contradicting this point.
3. Dr. Queen’s evidence was that the Chance fracture did not cause Ms. Aylwin’s death. He admitted that the Chance fracture was not a crush injury, caused by a force which was applied to crush Ms. Aylwin’s chest and back. He testified that the Chance fracture was right next to the rib injuries and that it was “just logical to assume that probably they all happened at the same time,” but he could not rule out two separate injuries.<sup>62</sup>
4. The microscopic morphological findings were not inconsistent with Ms. Aylwin having suffered the crushing injury at some point after the initial collapse but within a few hours of her death.
5. Dr. Queen testified that Ms. Aylwin’s fingers showed wrinkling commonly known as “washer woman’s hands,” which indicated that she had been in water. It was clear from other evidence, as I discuss below, that (a) there was a great deal of water on the rubble pile caused by a broken water pipe at the time of collapse, by hoses during the beam cutting on June 24, and by significant amounts of rain on June 23 and 24; (b) Ms. Aylwin’s hands, at the time she was found, were cupped under her mouth in a position that would have allowed her to drink; (c) the blood on her right hand had been transferred from somewhere else and appeared to have been wet or, as Dr. Queen testified, “relatively fresh.” Dr. Queen testified that, “hypothetically,” if Ms. Aylwin had been trapped under rubble but near water and able to drink it, that water would have relieved the dehydration. In any event, as I have noted, Dr. Queen admitted that he did not know when dehydration would start to be manifested in concentration levels.<sup>63</sup>

I note also that Dr. Queen testified that the inability to move one's ribcage or diaphragm as a result of a crushing injury, as he determined was the cause of death, can be less than complete – it might result in only partial obstruction. In those cases, death would be less rapid than if the obstruction was complete. Some people are crushed in this way and survive.<sup>64</sup> Consequently, even if the crushing injury was caused by the initial collapse, the objective evidence relied on by Dr. Queen is not inconsistent with Ms. Aylwin surviving for at least “a little over three hours” following the initial collapse.

## High creatinine levels – not of assistance in determining the cause or time of death

During the course of the hearing, an issue arose about the levels of creatinine in Ms. Aylwin's vitreous fluid at the time of her autopsy. After all the evidence on this issue was heard, it became apparent that the creatinine levels were of no assistance in determining Ms. Aylwin's cause or time of death. Because this issue was explored, however, I believe it is important that I explain the basis for that conclusion.

Creatinine is a chemical waste molecule that is generated from muscle metabolism and processed through the kidney. The levels of creatinine in bodily fluids can be affected by kidney problems or hydration issues. The creatinine levels in Ms. Aylwin's vitreous fluid were 153 millimoles per litre. Dr. Queen testified that that was about 150 percent higher than normal levels. He agreed that this level was an indication of either dehydration or renal (kidney) dysfunction. As I have indicated, he ruled out dehydration because of the normal levels of sodium, chloride, and urea nitrogen. It was his evidence that, as a result, “you've really only got one thing left. You've got kidney disease ...” He testified that, because Ms. Aylwin was highly prone to kidney disease, and because of the potential for a laboratory error in the sampling or testing, “the creatinine could be a bit of an outlier, but it really doesn't bother me.”<sup>65</sup>

On further questioning, Dr. Queen agreed that the high creatinine levels could have been the result of kidney dysfunction that was caused by Ms. Aylwin being under the pile of rubble for some length of time before the crush injury that caused fatal asphyxia (which would support a conclusion that Ms. Aylwin survived for some time after the collapse).<sup>66</sup> He was shown a chart that summarized creatinine tests in Ms. Aylwin's blood since 1991. The levels had been tested 40 times, at least once annually in most years. Every test was within the normal range of 53 to 115 millimoles per litre. The last test, on April 20, 2012, some two months before the collapse, showed levels of 71 millimoles per litre. The autopsy test of 153 millimoles per litre was more than twice that level; the highest creatinine level found in Ms. Aylwin's blood before the autopsy was 95 millimoles per litre in June 2008, four years earlier.<sup>67</sup>

When asked to give an opinion on the reason for this significant increase in creatinine levels, Dr. Queen testified:

So the possibilities are that she had a sudden decomposition of her renal function and certainly diabetics can do that, or the other possibility is what I mentioned before. There's some kind of technical issue around the fact that this sample was suboptimal or some issue in the laboratory.<sup>68</sup>

It was his opinion that, based on the “entire picture” and “all of the evidence,” the sudden increase in creatinine levels was not the result of kidney dysfunction after the initial collapse and before the injury that caused crush asphyxia.<sup>69</sup>

Commission counsel sought out further expert evidence to deal with the issue of the abnormally high levels of creatinine. Dr. Gerald Posen is a retired nephrologist (a medical specialist in diseases of the kidney) with a long and distinguished career. He reviewed Dr. Queen's autopsy report and Ms. Aylwin's medical records. He was asked to consider whether the high creatinine level was the result of acute renal failure after the accident, which would imply that the person was alive for some time after the crush injury. He concluded that the high creatinine levels could not support that conclusion.<sup>70</sup>



Ms. Aylwin had suffered from diabetes since the age of 13. On April 20, 2012, the last visit to her physician before the collapse, her blood pressure was higher than recommended for a diabetic. Her physician increased her dosage of Fosinopril, a drug that is used to lower blood pressure in diabetics. One of the side effects of this drug is to increase creatinine levels in the blood, particularly when the kidneys have been affected by diabetes. The microscopic examination of the kidneys done during the autopsy showed that Ms. Aylwin's kidneys had been affected by her diabetes. It was therefore Dr. Posen's opinion that the increased dosage may have contributed to Ms. Aylwin's increased creatinine level.<sup>71</sup>

Dr. Posen explained that, although an increase in creatinine in the blood or vitreous fluid can be caused by renal failure, suggesting that Ms. Aylwin may have lived a significant period of time after the renal failure and before her death, he would also expect to see an increase in the urea nitrogen levels if that had been the case. Ms. Aylwin's urea nitrogen levels were normal at the autopsy. Furthermore, if the creatinine levels had been caused by the crush injury and Ms. Aylwin had survived for a significant period of time after that injury, he would have expected to see increased levels of myoglobin, a protein found in muscle tissue. The autopsy tests of kidney cells and urine showed no signs that would be associated with increased myoglobin. He concluded, as a result, that the increased creatinine levels were not due to acute kidney failure but to other factors, and that Ms. Aylwin died very soon after the crush injury.<sup>72</sup>

Dr. Posen was asked whether he had any opinion about how long after the Mall collapse Ms. Aylwin suffered the crush injury. He testified that he could not give an opinion on that subject, because it was outside his area of expertise. In cross-examination, he noted that her urea nitrogen levels were normal so she was not dehydrated, but that there may have been water available. He testified that he could only say that her kidneys were functioning before the crush injury, but that he could not say how long that was.<sup>73</sup>

### **Dr. Feldman's evidence: Persons trapped in structural collapses can survive for periods of time**

Dr. Queen testified that one of the reasons he concluded that Ms. Aylwin's death occurred at or nearly immediately after the time of the original collapse was the nature of the collapse – that the mortality rate would be high.<sup>74</sup> Dr. Michael Feldman, the emergency room physician assisting the Heavy Urban Search and Rescue (HUSAR / TF3) team, made it clear that persons trapped in such a collapse can survive. As I have indicated, he emailed Capt. Tony Comella and Cmdr. Michael McCallion at 10:54 a.m. on June 25, writing that "a rule of thumb is that a trapped person can survive 3 days without water" and that, if there were no more signs of life detected by 72 hours after the collapse, it would be acceptable medically to consider it a body recovery operation following that point. He testified that the content of this email was based on his knowledge as an emergency physician, his training at the disaster medical specialist course, his reading of some of the literature about the kinds of things that one might encounter, and his inspection of the rubble pile.<sup>75</sup>

An article published in 2005 in the journal *Prehospital and Disaster Medicine*, entitled "Surviving collapsed structure after earthquakes: A 'Time-to-Rescue' Analysis" was referred to by Dr. Feldman in a presentation he made about the Mall collapse and response. He asserted that it was a reputable source. The authors conducted a study of medical journal articles and media articles in an attempt to determine the range of survival times in earthquakes that caused collapsed-structure entrapment. After studying 34 earthquake events and 48 medical articles, the authors reported that the longest time to rescue a trapped survivor was between 13 and 19 days; the second-longest time was 8.7 days (209 hours). Twenty-five medical articles reported multiple rescues after 48 hours. Media reports described rescues occurring beyond Day 2 in 18 of 34 earthquakes, with the two longest reliably-reported survival times being 14 and 13 days after impact. The average maximum times reported from the 18 earthquakes was 6.8 days, and the median 5.75 days. The authors noted that, although

the data were not necessarily applicable to non-earthquake collapsed-structure events, the study findings may be useful for post-impact decision making and in establishing or revising incident priorities as the response evolves. An earlier literature search, in 1991, had indicated a dramatic drop-off in live finds during the 24 to 48 hours post-earthquake, which resulted in that time period being used as the “golden 48 hours” in early training for US Urban Search and Rescue teams. However, non-American teams operate under the “rule of fours,” which postulates that a victim can survive four minutes without air, four days without water, and four weeks without food. The authors concluded that, while their study’s findings do not contradict earlier impressions of a drop-off in the number of successful rescues after 48 hours, the many rescues accomplished after that time, particularly up to five days post-impact, suggest that the “intense rescue phase” should continue at least through this period. Dr. Feldman testified that he referred to the 2005 article in his post-event presentation because he thought it was “provocative” in extending the time for survival beyond the view, held by some, that the chance of rescue beyond 48 hours was low, and because he wanted to make people aware that the time could be extended in some circumstances.<sup>76</sup>

I conclude that the nature of the collapse does not assist me in determining when Ms. Aylwin died.

## There were voids in the rubble pile

If Ms. Aylwin survived for a period after the collapse, she would have had to have been in a “void” – a space surrounded by pieces of concrete and rubble which would have allowed her to breathe. It is clear that there were such voids.

Cst. Ryan Cox gave evidence about the training he and other members of the OPP’s UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear and Explosive Response Team) received at Texas A&M University, in conformity with Standard 1670 of the National Fire Protection Association (NFPA). Annex J of that standard includes descriptions and depictions of different types of building collapses. Cst. Cox testified that the Mall collapse was of a type called a “pancake” collapse. Standard 1670 says this about a pancake collapse:

A pancake is formed when the bearing wall(s) or column(s) fails completely and an upper floor(s) drops onto a lower floor(s) causing it to collapse in a similar manner. Potential areas where victims might be located are under the floors and in voids formed by building contents and debris wedged between the floors.<sup>77</sup>

Cst. Cox agreed that there is always potential for small voids, although the probability of voids in a pancake floor collapse is lower than in other types of collapses. He was shown photographs of the rubble pile on June 23, before the crane had begun to remove any of the large pieces of concrete. He agreed that the photographs showed potential for a number of voids.<sup>78</sup>

Capt. Thomas of the Elliot Lake Fire Department testified that there were a “lot of voids” in the rubble pile, of different sizes. He said that he went into voids – which he described as a space between objects which had fallen – in the rubble pile, and that half of his body fit into some.<sup>79</sup> It was his evidence that the sound he heard that he described as a “muffled noise” at 3:28 p.m. on June 23, which I discuss below, was coming from a void.<sup>80</sup>

Although Capt. Darren Connors of the Elliot Lake Fire Department told the OPP that “there were no voids anywhere,” he explained that he meant that there were no voids that the firefighters could gain access to – “no simple void that any of us could crawl into to look, like a tunnel, per se, you know, nothing larger than being able to reach in with your arm or stick your face into.”<sup>81</sup> OPP Sgt. Jamie Gillespie testified that, at the time work was suspended on June 25, they had been able to see clothing fabric with a search camera which had been used to gain access through small voids.<sup>82</sup>



Photographs of the rubble pile introduced into evidence show that the pieces of concrete which formed the rubble pile were piled on top of each other at varying angles, producing many potential voids.<sup>83</sup> Figure 2.8.1 shows members of the Elliot Lake Fire Department looking in voids shortly after the collapse.<sup>84</sup> Photographs of Ms. Aylwin's body under the last two pieces of concrete show that she was lying under a slab of concrete that was at an approximately 25-degree angle (but higher at her head). A plastic chair or small table at the level of her upper back was not crushed. She was clearly caught by the concrete and would have been unable to move, but there appears to be a space that, if she had been alive, would have allowed her to breathe.<sup>85</sup>



**Figure 2.8.1** Firefighters examine voids in the rubble pile

Source Exhibit 7933

## **No evidence of shifting of the rubble pile after the first four or five hours, but one incident of vibration**

Capt. Thomas testified that the building was moving – that there were things dropping all around them “so obviously something is moving or settling.”<sup>86</sup> Later he testified that, in the first four or five hours, “the pile was settling and shifting.”<sup>87</sup>

Sgt. Gillespie testified that in the initial response, he heard

very small material, like small gravelly material sliding and then either I blocked it out or I didn't hear it anymore, but I didn't – I never once saw any real movement of the material within the pancake of the collapse. That, to me, there was no movement whatsoever.<sup>88</sup>

Cst. Patrick Waddick, Cst. Cox, and Capt. Comella all testified that they did not see any movement of the slabs in the pile while they were removing the concrete pieces with the crane.<sup>89</sup> Cst. Waddick also testified, however, that, just because he had not seen any movement with the structure around him, it did not mean there had not been movement.<sup>90</sup>

Don Sorel (Toronto Water / HUSAR), who was doing the rigging work on Sunday evening June 24, into the following morning, also testified that there was no shifting of the pile. He did testify, however, that, when he and Cst. Waddick were working on the pile, he felt a very slight vibration passing through the pile from south to north. He said that Cst. Waddick told him that he had felt it too, and they asked Capt. Chris Rowland, a team leader, if his team had done anything to cause it. Capt. Rowland replied that they had not – that his team was building laced-posts.<sup>91</sup>



## There was extensive evidence of water available to Ms. Aylwin

Capt. Thomas testified that when the firefighters arrived at the scene shortly after the collapse, one of the “big pipes inside the mall” had been sheared off and the water was pouring out.<sup>92</sup> Capt. Connors gave similar evidence, testifying that a 3- or 4-inch pipe was sheared off and fully flowing water onto the pile.<sup>93</sup>

Capt. Comella testified that, when HUSAR/TF3 arrived, there was “a lot of rain.”<sup>94</sup> He also testified that the notes he was making as the work was being done were getting “ruined by rainwater,” and that they had to go to Sgt. Gillespie’s truck to communicate the plan to him and to engineers Roger Jeffreys and James Cranford to “get out of the pouring rain.”<sup>95</sup> Staff Insp. William Neadles gave similar evidence, saying that “it was absolutely pouring rain” when they arrived, and that the notes that he had been writing “absolutely got drenched in the rain.”<sup>96</sup> Staff Insp. Neadles emailed Dr. Feldman at 4:18 a.m. on June 24 (shortly after HUSAR/TF3 had arrived), writing: “Just started to rain hard.”<sup>97</sup> Capt. Martin McRae also testified that when they arrived in Elliot Lake, it was “raining fairly hard,” so that his notes got wet and were difficult to read.<sup>98</sup>

Sgt. Gillespie testified that it rained the first night; he did not believe that it did the second night. He said that he did not recall the rain being “excessive by any means.” As far as he could see, it did not accumulate in the collapse area. However, when asked whether someone could access the water and “rehydrate themselves,” he said, “Anything is possible.”<sup>99</sup>

A note in the HUSAR/TF3 record attributed to Capt. Comella indicated that, at 12:25 a.m. on June 25, it was “still raining.”<sup>100</sup> When I asked him whether it had been raining continuously, he replied that “[i]t sure felt like it,” and that “shortly after arrival on scene it was coming down in buckets with moderate winds ... [I]t really didn’t let up much for a very long time and ... my recollection is that it got better over time, but through the night it was coming down quite hard.”<sup>101</sup>

Cmdr. McCallion testified that it was “pouring rain” when HUSAR/TF3 arrived.<sup>102</sup> Mr. Cranford, in contrast, testified that it was raining, but that he did not recall it being overly heavy, although he was inside for a portion of the evening.<sup>103</sup> Dr. Feldman’s email of June 25 to Cmdr. McCallion and Capt. Comella referred to “puddles” and stated that there may be access to rainwater / spilled water / drinks in the food court.<sup>104</sup>

Capt. Connors testified that he was standing on the second floor of the Mall, spraying water while the beam cutting was going on. He was aiming the water toward the underside of the beam where they were cutting, trying to get the water over the hole so it would not fill it with water.<sup>105</sup> The videos of that process show clearly that, while some of the water made its way across the hole to land on the second-floor food court across from where Capt. Connors was standing, much of the water fell into the hole and onto the pile. The spraying continued for more than 28 minutes.<sup>106</sup>

## “Signs of life”

I heard evidence of a number of “signs of life” between the initial collapse at 2:18 p.m. on June 23 and 5:30 a.m. on June 25. It is necessary for me to consider this evidence in order to attempt to estimate how long Ms. Aylwin may have remained alive after the collapse.

Dr. Queen testified that, if his opinion was correct that Ms. Aylwin died very quickly, with the possibility of a short survival interval, “by definition” the signs of life would have to be incorrect.<sup>107</sup> He gave the following evidence:

- Q. Doctor, one of the things that the Commissioner is going to be asked to determine is this very issue, and I’m wondering if you can assist in telling us how your opinion is consistent, that is, that on the balance of probabilities she was likely – Ms. Aylwin was likely to have died near the time of the collapse – how that is consistent with the fact that all of those indications of life, of which I’ve

described to you, were in the very location where her body was located? In other words, that seems to be, on one view of it, a coincidence which can be explained by some or all of the signs of life being accurate or simply as a fluke. Can you give us any explanation to assist?

A. Well, I'm obviously not an expert on this LifeLocator machine, and I'm not an expert on dogs.

If I was looking into it, though, I would have some very pointed questions.

I would want to know what is the specificity of these different techniques, or another way to phrase it is what is the false positive rate of these techniques.

Has anyone ever actually scientifically demonstrated what the false positives are in these techniques?

So does anybody have a clue, objectively and scientifically, of what the validity is of any of those techniques? And as far as some of the other things with – I understand, tapping and mumbling, again, that's not really in the area of forensic pathology. I would talk to a psychologist and ask them, you know, "How do people react in these kinds of situations? Is there an overwhelming wishful thinking going on? Is it easy to misinterpret things in a noisy chaotic scene?" So, I mean, there's a lot of questions I would have. I don't know any of the answers.

What I can tell you is that some of the things that I've done do have some scientific, objective, factual basis. They're not perfect, but I think when you take that and you look at everything together, my opinion remains the same, that I think she most likely died very quickly, but I can't rule out a short survival interval.<sup>108</sup>

Dr. Queen's final opinion can be compared with his opinion sent to Dr. Muir and Dr. Pollanen at 2:43 a.m. on June 28, after his initial review and before he had the analyses of the sodium, chloride, and urea nitrogen levels. At that time he had no cellular analyses available. Nor did he know anything about the signs of life other than what he had read or seen in the media. As noted above, he wrote:

despite the ... possible "signs of life" up to 48 hours after the collapse, I am highly skeptical and believe that this victim also died very quickly (her fingernails are totally intact and very clean showing no evidence of [having] tried to "claw her way out").<sup>109</sup>

His conclusion set out in his autopsy report some six months later was that the death was "most likely near-immediate ... after the crushing forces were applied." In his testimony before me, he made it clear that, in his view, those crushing forces were probably applied at or near the time of the collapse. His initial opinion, based almost entirely on the circumstantial evidence and his gross findings, was formed at an early stage and was not changed by later scientific analysis. The signs of life do not appear to have played any role in his conclusion.

Commissioner Goudge noted that forensic pathologists should be careful to avoid "confirmation bias" – "the situation that occurs when anyone, including pathologists, tends to seek out evidence to support or confirm an investigative theory or an expert opinion and excludes other theories or possible opinion."<sup>110</sup> I am alive to the possibility that Dr. Queen's opinion may have unconsciously been, to some extent, affected by an inclination to conform to his initial opinion, but I cannot express my concern in more specific or confident terms.

### June 23, 3:28 p.m. – muffled voice

Capt. Thomas testified that, at about 3:28 p.m. on June 23, he called out on the rubble pile: "Fire Department, can you hear me?" He said he heard a noise that he described as sounding like a muffled voice. He called out, "Can you give me your location?" and heard another muffled voice that sounded to him "like somebody responding, like a muffled voice." He called out and got responses back between six and 10 times over a 20-minute period. Although he got responses every time he asked a question, he could not make out what the person was saying. He thought that the sound was coming from a hole or void not large enough to get his hand into. He marked the approximate location (within 5 feet) of the hole by drawing a rectangle on a photograph of the scene of the collapse. That marked-up photograph was made an exhibit.<sup>111</sup>



### June 23, 3:30 p.m. – communication

Capt. Connors testified that he took over communication with the victim from Capt. Thomas at about 3:30 p.m. on June 23. He heard sounds in the same opening in the rubble pile as Capt. Connors had heard. Capt. Connors and Chief Paul Officer had the following recorded radio conversation, which was played at the Inquiry:

[Captain Connors] I think I'm managing to communicate with her and I am almost certain that she said she is a staff member from Dollarama so I don't know if we can get ahold of the Dollarama manager ... find out his schedule see who is unaccounted for and maybe that can help us better identify who we are dealing with and who we can talk to. [Chief Officer] Yeah, do you have a name? [Capt. Connors] No, Chief, most of it is just like really hard to understand so I get her to say yes I try to get her to say it twice and I am thinking that that is what she is trying to do with me.<sup>112</sup>

Capt. Connors testified that he was trying to have a simple conversation. He and the person did not exchange actual words. He received a response after 10 to 15 seconds, and it felt to him like it was a response to his question, not a noise from something else. He said that he did not think that it could have been anything other than him communicating with a live person. He asked about five questions, repeated two or three times each. At some point, he stopped the communication, but he could not recall whether he stopped hearing the sound or whether it stopped when he was asked to take a break and he handed off the job to someone else. He could not say how long he had been communicating with the person. He marked the approximate location of the sound on another copy of the photograph used by Capt. Thomas.<sup>113</sup>

### June 24, 9:30 a.m. – tapping

Sgt. Scott Fowlds and Sgt. Jim Lawson walked into the second floor of the Mall, above the rubble pile, at 9:30 a.m. on June 24. Sgt. Lawson called out: "[I]f you can hear me call out to my voice, make a sound." Sgt. Fowlds heard "a tapping sound." Sgt. Lawson called for "all quiet" so nobody else would talk, and then called out again: "[I]f you can hear our voice call out or make a sound." Sgt. Fowlds testified that he heard another single tap. Sgt. Lawson then said: "[I]f you can hear my voice tap twice shortly after I stop talking." Sgt. Fowlds then heard two taps. Sgt. Lawson then asked for three taps, and Sgt. Fowlds heard three taps. Sgt. Lawson then asked for another tap, but Sgt. Fowlds heard no more sounds. He described the "taps" as "a very hollow sound like when you tap on concrete," not like concrete hitting concrete but like flesh hitting concrete. He could not indicate exactly where on the rubble pile the noise was coming from, other than to say that it came from the collapse zone, not the side areas.<sup>114</sup>

### June 24, 12:10 p.m. – indication of live victim from canine Ranger

At 12:10 p.m. on June 24, Sgt. Fowlds, a trained canine handler, entered the building with his dog, Ranger, trained as a "live victim" rescue dog. Ranger ran up on the pile and searched it in a zigzag pattern. The dog started to bark, giving the indication that he had found a live victim. On another copy of the photograph marked by the other five witnesses whose evidence is set out in this section, Sgt. Fowlds marked the area in which the dog gave that indication. Ranger had cut himself above and to the side of his left eye as a result of jamming his head into the concrete, trying to reach the trapped person.<sup>115</sup>

### June 24, 9:30 p.m. – indication of live victim from canine Dare

Cst. Dan Bailey, also a trained canine handler, introduced his dog, Dare, into the Mall at 9:30 p.m. on June 24. Cst. Bailey was not allowed into the area of the rubble pile on the ground floor, so he asked Cst. Cox and Sgt. Gillespie to watch Dare from the second level of the Mall while Dare searched the pile. Dare moved around the pile, and Cst. Cox told Cst. Bailey that Dare had stopped and was sniffing into a void. Cst. Bailey then heard Dare bark "a couple of times." Cst. Cox told Cst. Bailey that Dare was trying to crawl into the void. Cst. Bailey concluded that Dare was indicating a live victim trapped within the rubble.<sup>116</sup>



Cst. Cox, also a trained canine handler, was standing on the second level of the Mall, and saw Dare enter and search the pile very thoroughly. Cst. Bailey could not see Dare. The dog went under a number of slabs and climbed up the escalator and back down onto the pile. Cst. Cox testified that Dare “showed a little bit of interest” right along the wall near the centre of the collapse, but did not give the signs used to indicate that a live victim has been found. Cst. Cox drew a line on another copy of the photograph marked by others to indicate this area. The dog then went to another location and, in Cst. Cox’s opinion, “caught an odour.” Dare’s head popped up, he walked in a circle, sat down, and barked twice. Dare was putting his nose in a small void between pieces of concrete. Cst. Cox marked that point with a dot on the photograph, and marked with a circle the general area where the dog walked in a circle and sat down.<sup>117</sup> Dare was trained to search for both live victims and dead victims. Cst. Cox also testified that there is a “gray area” where the odour is confusing to dogs, when the chemical reaction following death starts taking place. He thought that this confusion may have been an explanation for why Dare did not give a definite sign against the wall (the location where Mrs. Perizzolo’s body was located). There is nothing in Cst. Cox’s notes about this incident. He testified that this activity took place on June 23, but Cst. Bailey’s notes clearly indicate, and he testified, that it happened on June 24. I am satisfied that Cst. Cox got the date wrong when he testified without benefit of a note as to the incident or the date.<sup>118</sup>

### **June 24, 11:30 p.m. – sign of breathing from LifeLocator device**

At approximately 11:30 p.m. on June 24, Cst. Steve Hulsman deployed the LifeLocator at a spot where Sgt. Gillespie told him that the canine unit had given a sign of life. He placed the device on the concrete in four different spots in that general area, lowering it until it came into contact with the concrete. He marked three of those spots on another copy of the photograph used by the others.<sup>119</sup> Cst. Hulsman received four positive indications of breathing from the LifeLocator. The indications were sporadic, with reported depths of between 2.7 and 6.2 metres. His evidence was that the body was located approximately 2 metres below the top of the rubble pile. He could not adequately explain the difference in the reported depths or why the device was indicating a heartbeat some 4 metres below the concrete floor. He acknowledged that the machine was not being operated according to the manufacturer’s specifications in that there were people within 15 metres of the machine.<sup>120</sup>

Cst. Cox saw Cst. Hulsman deploy the LifeLocator device on June 24. His notes indicate that, at 11:30 p.m., Cst. Hulsman said that the device indicated a heartbeat (Cst. Cox’s word, not Cst. Hulsman’s) in a specific area near the centre of the pile.<sup>121</sup> Cst. Cox testified that the LifeLocator was placed “almost dead on exact” where Dare had barked.<sup>122</sup> Capt. McRae also saw Cst. Hulsman use the device. He marked on another copy of the photograph others had used the location of the device at the time that Cst. Hulsman announced the positive result. Capt. McRae also testified that people were within 15 metres of the device when it was being used, contrary to the manufacturer’s instructions.<sup>123</sup>

### **June 25, 5:03 a.m. – possible sign of deceased victim from canine Dare, but no sign from canine Ranger**

On June 25 at 5:03 a.m., Cst. Bailey was asked to have his canine search the rubble again, after several large concrete slabs had been removed. He went on to the pile with Dare, who was off his lead. Dare sniffed and made a “muffled sound” “like a bark” and stood looking down into the pile. The dog started to show indications of the way he acted when he found a cadaver. Cst. Bailey testified: “At this point now I’m starting to believe I don’t think he’s indicating on a live victim; ... it’s kind of – now we’re at the 50/50.” Later he testified that, because of the weak bark and the dog’s behaviour in sitting and looking and not the loud, sure barks and tail-wagging given to indicate a live victim, he believed that the victim being indicated was deceased. This indication was in “roughly the same location” in which Dare had earlier indicated a live victim. Cst. Bailey was shown a photograph of the pile that was taken on June 25 at 10:48 a.m. He testified that this photograph was consistent with his recollection

of the pile earlier that day, when Dare had carried out his search. Cst. Bailey marked the photograph where Dare had given his indication.<sup>124</sup>

As I have indicated above, Sgt. Fowlds deployed his dog, Ranger, off lead after Dare left. Although Ranger continued to work the area with a lot of interest, he did not give any indication. He was pulled off the pile after about 10 minutes.<sup>125</sup>

### **June 25, 5:30 a.m. – sign of breathing from LifeLocator device**

At approximately 5:30 a.m. on June 25, Cst. Hulsman used the LifeLocator again. He placed it at approximately the same location he had the previous evening. Again, it was not operated according to the manufacturer's specifications. The machine indicated breathing at somewhere between 2.7 and 4.3 metres below it. Cst. Hulsman testified that the machine did not indicate that anyone was moving.

In January 2013, Cst. Hulsman spoke to the LifeLocator's manufacturer, GSSI. GSSI had examined data files sent by Cst. Hulsman. The data file that GSSI reported on indicated motion as well as breathing. This indication did not really resolve anything because it was never established that the file GSSI analyzed in its report was a file from the Elliot Lake deployment. Cst. Hulsman was told that the analysis showed that people were moving between 4 and 10 metres from the unit. That discrepancy was never resolved, and I am consequently left in some doubt about the accuracy of the LifeLocator or the manner in which it was operated.<sup>126</sup>

### **Marked photographs show the same location for signs of life – where Ms. Aylwin's body was located**

The photographs marked by the witnesses to indicate the location on the rubble pile of the sounds, canine signs, and LifeLocator indications show a remarkable congruence. All the witnesses marked a spot within a few feet of each other. The location marked by each of the witnesses on these photographs was in the very location where Lucie Aylwin's body was located. This congruence is clearly shown by comparing Exhibit 9277, a photograph taken on June 27 at 1:06 p.m. and marked by Dr. Bradford to indicate the location of Ms. Aylwin's body before it was removed, with each of the photographs marked by the witnesses.

### **Canine signs of life and death can be relied on**

I heard evidence from Staff Sgt. Wayne Jacklin of the OPP about the reliability of dogs trained to find live victims and human remains. He is the training coordinator for the OPP canine program. Staff Sgt. Jacklin became a canine handler for the OPP in 1996. From 2000 to 2005, he was the training coordinator for the canine handlers, and in 2005 he was promoted to staff sergeant as the canine supervisor. He oversees all the operations of the OPP canine program. I am satisfied that he is highly trained and experienced with respect to the training and use of dogs for police operations, including search and rescue.<sup>127</sup>

Staff Sgt. Jacklin testified that there are two recognized standards for dog training: the Canadian National Standard and the US Federal Emergency Management Agency (FEMA) Standard. He assisted with the development of the Canadian National Standard.<sup>128</sup>

Certification of a dog for search and rescue requires extensive training and testing, over a three-year period, to establish that the dog can search independently, show commitment to a live victim, and give focused barks on victims with no false alerts. Dogs have to be re-certified each year. OPP canine officers all undergo a one-week dog-handling course at Texas A&M University as well as taking the Texas A&M collapsed-structure course.<sup>129</sup>

Dogs who find live victims are required under the FEMA standard to bark a minimum of six times, interspersed with digging in an attempt to penetrate to the victim. Staff Sgt. Jacklin testified, however, that the fact that a dog barks once, twice, or six times does not have any meaning in terms of what the dog has found; the requirement is that the dog commits to the victim to show that there is a live victim.<sup>130</sup>

There is a certification process for cadaver dogs as well, with an initial six-week course and then a week of training annually, in house at the OPP facility in Bolton. Staff Sgt. Jacklin described the OPP program as the “pinnacle of cadaver training.” Dogs who find human remains are required to give a passive indication – to sit or lie down on the site.<sup>131</sup>

The OPP had decided, before the Elliot Lake deployment, to stop training dogs to find both live victims and human remains. They had learned from their own experience and that of their colleagues in the United States that, when a dog was trained for both purposes, it was sometimes difficult to distinguish between the two – particularly in a situation where there may be both live victims and deceased persons in the same location.<sup>132</sup>

Staff Sgt. Jacklin explained that there is no clear answer to how long it takes for the scent from a person who has died to change significantly enough so that a dog can differentiate between a live person and human remains. There is a time after death when a dog could be indicating one way or the other, even though the person has died.<sup>133</sup> Staff Sgt. Jacklin was asked to comment about the general reliability of dogs. He testified that the use of dogs to detect scents is widespread and has increased in the years after September 11, 2001. “Nothing is perfect,” he said, “but given the right circumstances and the right training, you would be foolish not to appreciate the amazing work that dogs do.”<sup>134</sup>

Staff Sgt. Jacklin described Dare as a “Lamborghini” dog – a “very, very good dog, was really in his prime at this point.”<sup>135</sup> Dare had never failed a certification. He was certified for both live victim location and cadaver identification.<sup>136</sup> The officer also testified that when Dare’s behaviour changed from barking when first on the pile at 9:30 p.m. on June 24 to not barking at 5:03 a.m. on June 25, it could have been because of a change in the odour after death. As he put it, the certainty was the location:

I am certain, and I know he [Cst. Bailey] was too, this was the spot. The reason the dog’s barking is a – that’s a time period again. Is there somebody there that’s alive or is there somebody there that’s not alive? So the dog in the early, early stages may indicate, even if a person is deceased, could be indicating by barking. As time progressed, that gap has gotten bigger and the dog is not barking any more. So there could be that – it’s not confusion, it is this time lapse of a response ...” There could have been a switch between the first deployment and the second deployment.<sup>137</sup>

Sgt. Fowlds testified as well – about the training of service dogs in general, and Ranger specifically. He and his dog work in the Toronto Police Service and so do not come under the OPP program. Ranger was taken into the HUSAR/TF3 unit in February or March 2009, after originally being trained as a general service dog. He received further training for search and rescue, which involved agility on uneven surfaces, climbing up and down ladders, and searching on rubble piles, including the pile in Bolton owned by the OPP. That training, which was full time five days a week, started in September or October 2009 and finished in December of that year. Ranger was certified to Level 1 of the Canadian National Standard, which requires that the dog find two victims, with no false indications. Level 2 certification requires that the dog find all but one of a group of up to six victims. Ranger was certified to Level 2 in September 2012. The delay in certification was not because Ranger was not adequately skilled, but because the certification, which takes place in Brandon, Manitoba, was not available until September 2012. In addition to the certification, the dogs undergo ongoing training and exercises.<sup>138</sup>



## **Conclusion: Ms. Aylwin probably survived for some period of time after the collapse, but had likely died by 5:00 a.m. on June 25**

As Dr. Queen acknowledged, if Ms. Aylwin had died “near-immediate[ly]” after the initial Mall collapse, all the signs of life would have had to be incorrect.

There is no doubt that Capts. Thomas and Connors were certain in their belief that the sounds they heard were made by a trapped victim. The radio transmission between Capt. Connors and Chief Officer is clear evidence of how firmly Capt. Connors held that view. Similarly, Sgt. Fowlds clearly described three ascending numbers of taps in response to his instructions.

I have no reason to doubt the evidence I have heard of the clear indications of a live victim given on June 24 by Ranger at 12:10 p.m. and Dare at 9:30 p.m. Staff Sgt. Jacklin’s evidence that we do not know how long it takes after death for the scent of a live victim to dissipate and the scent of a deceased person to begin does, however, weaken the strength of that evidence. Similarly, the problems with the deployment of the LifeLocator device affect its reliability.

**All the indications were in the same place, and that place was where Ms. Aylwin’s body was ultimately located. It is highly improbable that all the signs of life were incorrect and yet, by complete coincidence, all in the same place and where the victim was found.**

One thing is clear, however. All the indications were in the same place, and that place was where Ms. Aylwin’s body was ultimately located. It is highly improbable that all the signs of life were incorrect and yet, by complete coincidence, all in the same place and where the victim was found. I can only conclude that at least some of those signs of life were probably accurate.

The sign that Dare gave at 5:00 a.m. on June 25 was ambiguous. It has been interpreted by Cst. Bailey as probably being an indication of a deceased victim. Staff Sgt. Jacklin agreed that this indication was possible. This sign occurred approximately 39 hours after the initial collapse. At about the same time, Ranger, trained to indicate a live victim, gave no sign.

Ms. Aylwin’s death before that time would not be inconsistent with any of the objective medical indicia discussed by Dr. Queen. He could not say when dehydration of a live victim would be indicated by concentration in the vitreous fluid of the substances for which he tested. He also testified, as did Dr. Feldman, that dehydration could be avoided if the victim had access to water, as Ms. Aylwin clearly did. Her hands were cupped as they would have been if she was trying to drink water puddled beneath her.

As a result, I conclude that it is probable (though by no means certain) that Ms. Aylwin lived for some period of time after the initial collapse. By 5:00 a.m. on June 25, however, it is probable that she had died.

## Notes

- <sup>1</sup> Perizzolo testimony, August 7, 2013, pp. 19861–3.
- <sup>2</sup> Aylwin testimony, August 7, 2013, pp. 19961–4.
- <sup>3</sup> Thomas testimony, August 15, 2013, pp. 21055–7.
- <sup>4</sup> Exhibit 9237; Bradford testimony, August 29, 2013, p. 23173.
- <sup>5</sup> Queen testimony, September 20, 2013, pp. 26449–51.
- <sup>6</sup> Queen testimony, September 20, 2013, pp. 26451–3.
- <sup>7</sup> Exhibit 9235.
- <sup>8</sup> Bradford testimony, August 29, 2013, pp. 23138, 23143–6.
- <sup>9</sup> Bradford testimony, August 29, 2013, p. 23219, Exhibit 9254; Exhibit 9246, p. 02.
- <sup>10</sup> Bradford testimony, August 29, 2013, pp. 23224–5.
- <sup>11</sup> Exhibit 9258.
- <sup>12</sup> Bradford testimony, August 29, 2013, pp. 23230–1.
- <sup>13</sup> Exhibit 9259; Queen testimony, September 20, 2013, p. 26464.
- <sup>14</sup> Exhibit 9259.
- <sup>15</sup> Queen testimony, September 20, 2013, p. 26468.
- <sup>16</sup> Bradford testimony, August 29, 2013, pp. 23181–2; Exhibit 9277.
- <sup>17</sup> Bradford testimony, August 29, 2013, pp. 23190–1.
- <sup>18</sup> Bradford testimony, August 29, 2013, pp. 23193–5.
- <sup>19</sup> Exhibit 9235.
- <sup>20</sup> Exhibit 9246, p. 02.
- <sup>21</sup> Exhibit 9247.
- <sup>22</sup> Exhibit 9233.
- <sup>23</sup> Bradford testimony, August 29, pp. 23295–7.
- <sup>24</sup> Exhibit 9260, p. 04; Queen testimony, September 20, 2013, p. 26470.
- <sup>25</sup> Queen testimony, September 20, 2013, pp. 26470–3.
- <sup>26</sup> Queen testimony, September 20, 2013, pp. 26474–5.
- <sup>27</sup> Queen testimony, September 20, 2013, pp. 26476–80, 26486–7.
- <sup>28</sup> Queen testimony, September 20, 2013, pp. 26480–2, 26486–7.
- <sup>29</sup> Exhibit 9260, pp. 09–10; Queen testimony, September 20, 2013, pp. 26486–7.
- <sup>30</sup> Exhibit 9260, p. 09; Queen testimony, September 20, 2013, pp. 26487–8.
- <sup>31</sup> Exhibit 9245, p. 008; Queen testimony, September 20, 2013, p. 26496.
- <sup>32</sup> Exhibit 9240, p. 59; Exhibit 9674, pp. 004, 006; Queen testimony, September 20, 2013, pp. 26495, 26497.
- <sup>33</sup> Exhibit 9674, p. 010; Queen testimony, September 20, 2013, p. 26499.
- <sup>34</sup> Exhibit 9260, p. 05; Queen testimony, September 20, 2013, pp. 26459, 26507.
- <sup>35</sup> Exhibit 9260, p. 006; Queen testimony, September 20, 2013, pp. 26508–9.
- <sup>36</sup> Exhibit 9260, p. 010.
- <sup>37</sup> Queen testimony, September 20, 2013, pp. 26511–15.
- <sup>38</sup> Exhibit 9260, p. 010.
- <sup>39</sup> Queen testimony, September 20, 2013, p. 26517.
- <sup>40</sup> Exhibit 9260, p. 010.
- <sup>41</sup> Queen testimony, September 20, 2013, p. 26519.
- <sup>42</sup> Exhibit 9260, p. 010.
- <sup>43</sup> Exhibit 9245, p. 008; Queen testimony, September 20, 2013, p. 26521.
- <sup>44</sup> Exhibit 9260, p. 010.
- <sup>45</sup> Exhibit 9261; Queen testimony, September 20, 2013, pp. 26521–4.
- <sup>46</sup> Exhibit 9260, p. 010.
- <sup>47</sup> Queen testimony, September 20, 2013, pp. 26525–6.
- <sup>48</sup> Queen testimony, September 20, 2013, pp. 26526–7.
- <sup>49</sup> Exhibit 9245, p. 009; Queen testimony, September 20, 2013, pp. 26528–9.
- <sup>50</sup> Queen testimony, September 20, 2013, pp. 26527–34.
- <sup>51</sup> Queen testimony, September 20, 2013, pp. 26533–5.
- <sup>52</sup> Ontario, *Report of the Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Ontario Ministry of the Attorney General, 2008), vol. 3, 408 (Commissioner Stephen T. Goudge).
- <sup>53</sup> Exhibit 9260, p. 010.
- <sup>54</sup> Queen testimony, September 20, 2013, pp. 26552–3.
- <sup>55</sup> Queen testimony, September 20, 2013, pp. 26565–6.
- <sup>56</sup> Queen testimony, September 20, 2013, p. 26553.
- <sup>57</sup> Queen testimony, September 20, 2013, pp. 26554–5.
- <sup>58</sup> Queen testimony, September 20, 2013, p. 26556.
- <sup>59</sup> Queen testimony, September 20, 2013, pp. 26530–3; 26545.
- <sup>60</sup> Queen testimony, September 20, 2013, pp. 26553–4.
- <sup>61</sup> Ontario, *Report of the Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Ontario Ministry of the Attorney General, 2008), vol. 3, 422 (Commissioner Stephen T. Goudge).
- <sup>62</sup> Queen testimony, September 20, 2013, p. 26556.
- <sup>63</sup> Queen testimony, September 20, 2013, p. 26551.
- <sup>64</sup> Queen testimony, September 20, 2013, pp. 26515–16.
- <sup>65</sup> Queen testimony, September 20, 2013, pp. 26545–6.
- <sup>66</sup> Queen testimony, September 20, 2013, p. 26551.
- <sup>67</sup> Exhibit 9675.
- <sup>68</sup> Queen testimony, September 20, 2013, p. 26549.
- <sup>69</sup> Queen testimony, September 20, 2013, pp. 26549–51.
- <sup>70</sup> Posen testimony, October 4, 2013, pp. 28244–8.
- <sup>71</sup> Exhibit 9893; Posen testimony, October 4, 2013, pp. 28248–58.
- <sup>72</sup> Exhibit 9893; Posen testimony, October 4, 2013, pp. 28258–63.
- <sup>73</sup> Posen testimony, October 4, 2013, pp. 28263–6.
- <sup>74</sup> Queen testimony, September 20, 2013, pp. 26553–4.
- <sup>75</sup> Exhibit 7781; Feldman testimony, September 18, 2013, p. 26031.
- <sup>76</sup> Exhibit 9589; Feldman testimony, September 18, 2013, pp. 26049–52.
- <sup>77</sup> Exhibit 7834, p. 084.
- <sup>78</sup> Cox testimony, August 26, 2013, pp. 22230–3.
- <sup>79</sup> Thomas testimony, August 20, 2013, pp. 21223–4.
- <sup>80</sup> Thomas testimony, August 15, 2013, p. 21043.
- <sup>81</sup> Connors testimony, August 21, 2013, pp. 21423–4.
- <sup>82</sup> Gillespie testimony, September 3, 2013, p. 23681.
- <sup>83</sup> Exhibits 7932, 7933.
- <sup>84</sup> Exhibit 7933.
- <sup>85</sup> Exhibit 9245.
- <sup>86</sup> Thomas testimony, August 20, 2013, p. 21225.
- <sup>87</sup> Thomas testimony, August 20, 2013, p. 21200.
- <sup>88</sup> Gillespie testimony, September 3, 2013, p. 23646.
- <sup>89</sup> Waddick testimony, August 23, 2013, pp. 22018–19; Cox testimony, August 26, 2013, p. 26; Comella testimony, September 5, 2013, p. 24331.
- <sup>90</sup> Waddick testimony, August 23, 2013, p. 22074.
- <sup>91</sup> Sorel testimony, October 1, 2013, pp. 27583–4.
- <sup>92</sup> Thomas testimony, August 20, 2013, p. 21197.
- <sup>93</sup> Thomas testimony, August 21, 2013, p. 21570.
- <sup>94</sup> Comella testimony, September 4, 2013, p. 23920.
- <sup>95</sup> Comella testimony, September 4, 2013, p. 24040; September 5, 2013, p. 24121.
- <sup>96</sup> Needles testimony, September 10, 2013, pp. 25239, 25280.
- <sup>97</sup> Exhibit 6725.
- <sup>98</sup> McRae testimony, September 25, 2013, p. 27178.
- <sup>99</sup> Gillespie testimony, September 3, 2013, pp. 23714–15.
- <sup>100</sup> Exhibit 6393, p. 7.

- <sup>101</sup> Comella testimony, September 5, 2013, p. 24206.
- <sup>102</sup> McCallion testimony, September 6, 2013, pp. 24390, 24412.
- <sup>103</sup> Cranford testimony, September 9, 2013, p. 24866.
- <sup>104</sup> Exhibit 7781.
- <sup>105</sup> Connors testimony, August 21, 2013, pp. 21431–2.
- <sup>106</sup> Exhibits 7828, 7829.
- <sup>107</sup> Queen testimony, September 20, 2013, p. 26561.
- <sup>108</sup> Queen testimony, September 20, 2013, pp. 26559–26661.
- <sup>109</sup> Exhibit 9235, p. 02.
- <sup>110</sup> Ontario, *Report of the Inquiry into Pediatric Forensic Pathology in Ontario* (Toronto: Ontario Ministry of the Attorney General, 2008), vol. 3, 424 (Commissioner Stephen T. Goudge).
- <sup>111</sup> Thomas testimony, August 15, 2013, pp. 21041–7; Exhibit 8104.
- <sup>112</sup> Exhibit 6296.
- <sup>113</sup> Connors testimony, August 20, 2013, pp. 21381–90.
- <sup>114</sup> Fowlds testimony, September 19, 2013, pp. 26315–26.
- <sup>115</sup> Fowlds testimony, September 19, 2013, pp. 26330–5.
- <sup>116</sup> Bailey testimony, August 27, 2013, pp. 22739–49; Exhibit 6374.
- <sup>117</sup> Exhibit 9265.
- <sup>118</sup> Exhibit 6377 and Exhibit 6374, p. 02; Cox testimony, August 26, 2013, pp. 22331–42; Bailey testimony, August 27, 2013, pp. 22735–46.
- <sup>119</sup> Exhibit 9276.
- <sup>120</sup> Hulsman testimony, August 28, 2013, pp. 23005–30.
- <sup>121</sup> Exhibit 6377.
- <sup>122</sup> Cox testimony, August 26, 2013, p. 22342.
- <sup>123</sup> McRae testimony, September 25, 2013, pp. 27232–5.
- <sup>124</sup> Bailey testimony, August 27, 2013, pp. 22758–61; Exhibit 9266.
- <sup>125</sup> Fowlds testimony, September 19, 2013, pp. 26341–7.
- <sup>126</sup> Hulsman testimony, August 28, 2013, pp. 23032–46.
- <sup>127</sup> Jacklin testimony, August 27, 2013, pp. 22499–502.
- <sup>128</sup> Jacklin testimony, August 27, 2013, pp. 22531–2.
- <sup>129</sup> Jacklin testimony, August 27, 2013, pp. 22537, 22551.
- <sup>130</sup> Jacklin testimony, August 27, 2013, pp. 22533–4, 22537, 22548–9.
- <sup>131</sup> Jacklin testimony, August 27, 2013, pp. 22549, 22564–5.
- <sup>132</sup> Jacklin testimony, August 27, 2013, pp. 22594–7.
- <sup>133</sup> Jacklin testimony, August 27, 2013, pp. 22598–601.
- <sup>134</sup> Jacklin testimony, August 27, 2013, pp. 22607–8.
- <sup>135</sup> Jacklin testimony, August 27, 2013, p. 22586.
- <sup>136</sup> Jacklin testimony, August 27, 2013, pp. 22591–2.
- <sup>137</sup> Jacklin testimony, August 27, 2013, pp. 22635–8.
- <sup>138</sup> Fowlds testimony, September 19, 2013, pp. 26295–304.



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## HUSAR/TF3 fails to conduct an after-action review

The Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3) did not conduct a formal debriefing, nor did the team ever produce an after-action report.<sup>1</sup> HUSAR/TF3 members universally recognized the importance of debriefings and after-action reports. Moreover, the team's own operating manual, HUSAR Operating Manual 2007,<sup>\*</sup> seems to impose a requirement on it to engage in a debriefing process and critique following any deployment:

The HUSAR team will terminate the incident by completing the following tasks:

- Assist in the incident debriefing
- Assist in the incident critique
- Assist in the preparation of reports and documentation of the incident<sup>†</sup>

Many factors may have contributed to the absence of a proper debriefing and after-action report, including the fact that HUSAR/TF3 appears not to have conducted debriefings and produced after-action reports following past deployments. However, I am satisfied, based on the evidence set out below, that at least one motivating factor was HUSAR/TF3's defensive attitude toward criticism of possible mistakes and a desire to shield any internal discord about the deployment from review by this Commission.

## HUSAR/TF3 misses the opportunity to conduct a debriefing before leaving Elliot Lake

On June 27, HUSAR/TF3 packed up its operations. Before getting on a bus to Sudbury, Staff Insp. William Neadles thanked those present for their efforts, but did not attempt to conduct a debriefing session. He cited fatigue and raw emotions as his justification for this failure, even though he recognized the importance of debriefings:

It is my belief that ... you have to have an opportunity to step away from the event before you can actually engage in a good debrief. So taking them through things now when their emotions are very, very raw wouldn't have accomplished as much as a good debrief after some period of time later was there.<sup>2</sup>

Despite this suggestion that he was merely waiting for the right moment, Staff Insp. Neadles did not attempt to bring the team together for a debriefing once his team had had a chance to rest.

Many HUSAR/TF3 members spent the night in Sudbury and then drove back to Toronto. Again, no debriefing occurred, other than by way of informal and random discussions among team members at dinner and during the ride. Some people slept while others talked. No notes were taken of these conversations and nothing was circulated as a follow-up to educate those not on the bus back with the others, such as Capt. Tony Comella and Sgt. Phil Glavin.<sup>3</sup>

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<sup>\*</sup> Exhibit 769. The 2007 manual is noted to be a draft version. Cpt. Comella thought it had been finalized recently, but could not say with certainty: Comella testimony, September 4, 2013, p. 24014.

<sup>†</sup> Exhibit 769, p. 05. Cpt. Comella suggested that this section of the manual may not necessarily impose a requirement on HUSAR/TF3 to conduct its own debriefing, but instead to co-operate with any debriefing and critique held by the incident commander of an incident involving TF3. For example, had Chief Officer held a debrief, TF3 would have been required to assist him: Comella testimony, September 4, 2013, p. 24017.



## **HUSAR/TF3 has never conducted debriefings or produced after-action reports**

Capt. Comella and Cmdr. Michael McCallion both said HUSAR/TF3 did not normally conduct debriefings or produce after-action reports. Indeed, no debriefings were held for past deployments.<sup>4</sup> Staff Insp. Neadles confirmed this evidence.<sup>5</sup> This practice was followed despite agreement from Staff Insp. Neadles and Capt. Comella that debriefings and after-action reports are useful and potentially beneficial tools for any organization.<sup>6</sup>

Staff Insp. Neadles and Capt. Comella both suggested that the absence of debriefings and after-action reports related to scheduling problems and financial restrictions. They cited the difficulties associated with scheduling a meeting and paying team members from police, fire, and emergency medical services.<sup>7</sup>

It is difficult for me to accept that finances and scheduling were the real reasons behind the lack of a debriefing and after-action report in this case. Indeed, Capt. Comella agreed that there were opportunities to hold a partial debriefing at the hotel in Sudbury or on the bus back to Toronto. No additional costs would have been incurred and no scheduling difficulties created. When pressed, he agreed that cost was not the issue for the Elliot Lake deployment.<sup>8</sup> In the end, he said he simply couldn't offer a reason for the failure to debrief:

I can't offer a reason why it wasn't done. It would have been an ideal situation. I wasn't with the team when we returned home. I didn't stay in Sudbury. The Site Commanders could have done that if they had chose[n] to. It would have been their decision. They're leading the team at that stage of the game. It would have been an ideal opportunity, perhaps. Certainly on the surface it appears it was a missed opportunity.<sup>9</sup>

Capt. Martin McRae and Cmdr. McCallion, who similarly recognized the importance of debriefing sessions, also initially attributed the absence of one to the difficulties associated with different schedules, different agencies, and the absence of a mechanism to fund such a meeting. When pressed, however, Cmdr. McCallion conceded that it might have been possible, at no additional cost, to have had team members fill out a sheet of paper while they were on the bus back from deployment or otherwise conduct some type of a debriefing while the team was, for the most part, still together.<sup>10</sup>

## **Staff Insp. Neadles is approached by a team member to discuss deficiencies during the deployment, but no meeting occurs**

Don Sorel, one of the riggers during the Elliot Lake deployment, wrote to Staff Insp. Neadles on July 4, 2012.<sup>11</sup> His initial email simply asked whether he was okay and how his vacation was going. In testimony, Mr. Sorel explained that he was aware of the media criticism of Staff Insp. Neadles, someone he had a lot of respect for. He wanted to make sure he was okay.<sup>12</sup>

In addition, however, Mr. Sorel told the Commission that he wished to talk to Staff Insp. Neadles about what he perceived as a lack of self-sufficiency during the deployment. HUSAR/TF3 was supposed to have its own camp, beds, kitchen, water system, and washrooms, but during the deployment a lot of these items were missing. He thought it a bad idea for HUSAR/TF3 to have deployed in this manner. He referred to the mantra, "One bad meal can destroy a mission," saying HUSAR/TF3 was not supposed to eat civilian food (to avoid risks from food poisoning) or have civilians at the rescue scene (something he witnessed). He also saw other potential dangers from failing to have the HUSAR/TF3 camp use its own materials, such as the inability to know where all the team members were when sleeping and resting off-site, and the inability to control what members said to others about the mission.<sup>13</sup>

Staff Insp. Needles understood that Mr. Sorel wished to discuss areas for improvement, along with a “minor confrontation” that had occurred between Cmdr. McCallion and Mr. Sorel during the rigging process.<sup>14</sup>

In the end, it does not appear that Mr. Sorel was able to bring his concerns to Staff Insp. Needles’s attention, let alone to the rest of the team. Staff Insp. Needles responded to Mr. Sorel’s initial email by expressing great frustration at the way he was being portrayed in the media:

Don, thanks for the thoughts ... I am ok, but a little frustrating to listen and watch them chew my career up and not be able to defend it ... but that is the game we are in ...

I am off most of this week and next and finally recovering from lack of sleep ... all good ...

I know you want to meet and Mike [McCallion] and I have talked about this and are more than willing to grab a coffee with you to discuss issues ...

I have quit HUSAR (temporarily) until Fire puts the Planning piece in place ... I have no records, notes, reports or paperwork from this deployment and it is the most critical thing I need going into a criminal investigation and a Civil law suit ... I have fuck all pretty much ... but they have their rescue ...

Pathetic.<sup>15</sup>

Mr. Sorel wrote back, consoling and praising Staff Insp. Needles, but also explaining why he wished to discuss what went wrong, and mentioning “fundamental errors made by our team” and “the issue with the O.P.P.” He wrote:

You have no reason to beat yourself up. You at least had the backbone and fortitude to make a most difficult decision based on the expertise of resources you had available.

I want to meet with you and Mike for this reason alone. I like having you and Mike in the command position and want to help keep you there. I do not want to see command revert back to just Fire. I want to offer you my opinion on what I saw and witnessed during the short time I was there. This is to help you both out not to criticise. There were fundamental errors made by our team on the ground and of course the issue with the O.P.P. The O.P.P. issue was supposed to have been addressed after the exercise in Thunder Bay but obviously it wasn’t. With your knowledge and expertise we need to keep you as an integral part of the team. You will never stand alone although right now you may feel like you are.

Stand tall, stand proud as the team stands proud around you.<sup>16</sup>

Since no proper debriefing was held, Staff Insp. Needles and Cmdr. McCallion were left to guess what Mr. Sorel meant when he spoke of fundamental errors and issues with the OPP.<sup>17</sup>

## Capt. Comella seeks feedback by email, but few respond

Capt. Comella did attempt to initiate a debriefing process. On July 13, 2012, he sent an email invitation to HUSAR/TF3 seeking feedback on lessons learned from the experience:

Thanks for a great job done in Elliot Lake!!!!!!

All team members that responded to Elliot Lake are now asked to take some time to put your thoughts about the call on paper. We are interested in hearing about how you think we did as a team and what lessons that we can learn from the experience. Please compile this information and send it to me at ... at your earliest opportunity. We would like to use this information in our after action reporting and future training initiatives.<sup>18</sup>

Capt. Comella received what he termed a “very poor response” to his request.<sup>19</sup> I agree with his assessment. There were only three written responses to his request. The after-action report contemplated in the email was never produced.<sup>20</sup>

Staff Insp. Neadles did not reply. He told the Commission that, because he was in a command position, he waited, hoping there would be a significant response that he could then review with the other team leaders; he would then have provided his input.<sup>21</sup>

Capt. McRae said he did not respond to the email in writing, but that he and Capt. Comella talked extensively about the incident. He did not feel it necessary to reply in writing.<sup>22</sup>

Cmdr. McCallion did not respond and candidly admitted that he held back in order to avoid scrutiny of his comments during this Inquiry:

Q. Right. Number one, did you respond?

A. No, I didn't.

Q. How come?

A. I felt that this actual inquiry might be something that – my piece would get out and I just didn't want to prejudice what I said there and what I said here.<sup>23</sup>

Mr. Sorel did reply, but only to question the wisdom of self-critique with a pending inquiry and criminal investigation: "Is our self-critique a good idea at this point with a criminal investigation underway? Or a possible inquest?"<sup>24</sup>

Sgt. Glavin, who agreed that a debriefing following the Elliot Lake deployment would have been a good thing, did not respond to Capt. Comella's invitation. He, too, cited the pending inquiry and said he also shied away from a debriefing because he felt it was too little, too late. He told the Commission he thought the debriefing should have occurred as soon as the team got back to Toronto.<sup>25</sup>

Capt. Comella confirmed that one individual, Kent Burtenshaw, did reply.<sup>26</sup> Mr. Burtenshaw was a newer HUSAR/TF3 member, based with Toronto Fire Services. He had previous military experience, having served Canada on three overseas missions. Mr. Burtenshaw provided some minor but helpful suggestions for improvement. He felt the team should have had a guide, such as local police, before driving into town. He made suggestions for better convoy procedures for the drive up. He suggested new tools and equipment for the team, such as properly labelled hard hats, uniforms for drivers, durable laundry bags, and a bag to store respirators when not in use. His most pertinent feedback related to his personal confusion about the command structure and the absence of regular briefings for the HUSAR/TF3 rank and file:

Passage of information. At no point in the deployment was I ever really sure of the chain of command, and who was fulfilling what role in the higher headquarters. To this day I'm not sure where you [Capt. Comella] or Marty fit into the big picture. It was obvious you were both actively involved in the handling of the team, but [I'm] not sure of what your roles were. I believe a brief at the start of the deployment would have made it much clearer. I arrived very late to the bldg on the Sat night due to my involvement with loading the vehicles. Maybe a brief was conducted prior to my arrival. It is highly likely, though, that at this point in time, the plan still had not been completely formulated due to lack of information. Through[out] the deployment, we were forced to get all of our information from the internet. I believe we should have gotten a daily brief of the overall situation, in order to get the facts, as opposed to the interpretations of the media.<sup>27</sup>

Capt. Comella told the Commission Mr. Burtenshaw's point of view was a valid one, from the "perspective of a brand new team member, in the last year or so." He said the team hasn't had a chance to exercise since the event, but next time it did, HUSAR/TF3 intended to provide more information about the hierarchy, including operational job descriptions. Mr. Burtenshaw's comment "didn't fall on deaf ears."<sup>28</sup> Capt. Comella told the Commission, however, that he could not understand why Mr. Burtenshaw felt he did not have good information during the deployment: "[A]ll he had to do was ask whatever questions that he had, and his direct supervisor would have



given him the answers.” Capt. Comella felt that Mr. Burtenshaw had all the information he needed to understand the orders he was receiving.<sup>29</sup>

Capt. Comella also received feedback from Michael Strapko, also with Toronto Fire Services and involved with logistics for HUSAR/TF3.<sup>30</sup> His recommendations appeared to focus chiefly on delays and poor communications. Mr. Strapko considered that there had been an initial lack of urgency:

Initially, team spirit lacked a sense of urgency. Lollygagging overrode a spirit of emergency response. There were feelings of denial that we would be called off by the OPP as we were for the Windsor collapse.<sup>31</sup>

Mr. Strapko therefore suggested that a portion of the search team, with medics and sufficient equipment, deploy in advance of the rest of the team. The roll-off truck (carrying lumber) could be the last vehicle to arrive, being the slowest, or simply not be deployed. He made other suggestions for getting to the scene quickly and deploying quickly once there, such as having a bus with toilet facilities and allowing certain members to drive directly to the scene instead of waiting for everyone to muster at one place before anyone could depart.<sup>32</sup>

Mr. Strapko therefore suggested that a portion of the search team, with medics and sufficient equipment, deploy in advance of the rest of the team. The roll-off truck (carrying lumber) could be the last vehicle to arrive, being the slowest, or simply not be deployed.

On the communications front, Mr. Strapko suggested Blackberries for the whole team, for “readiness, research, and ongoing status updates during emergencies,” with “wallet cards” listing all team member phone / email contacts.<sup>33</sup> In terms of external communications, Mr. Strapko said “media and public relations were atrocious.” He took particular issue with the announcement that rescue efforts were terminated, describing it as “an international public relations disaster.” He suggested a strategic approach in the future involving multiple, alternative rescue plans and felt that HUSAR/TF3 should “**NEVER** halt rescue efforts at any point or time” [emphasis in original]. He made several suggestions for better media and public relations, including regular media scrums. HUSAR/TF3’s logistics branch, which he was a part of, could be responsible for media and public relations if staffed properly.\*

Capt. Comella was asked to comment on Mr. Strapko’s criticisms. He could not understand why Mr. Strapko felt there was a lack of urgency in the beginning and said that, from his perspective, he understood that there would most certainly be a rescue: “We were eagerly awaiting our arrival time, that’s for sure. We wanted to get here as soon as we could.”<sup>34</sup>

Dr. Michael Feldman, the team doctor and an emergency room physician, also replied to Capt. Comella’s email. He copied Staff Insp. Neadles and congratulated him on having done an “outstanding job despite relentless media scrutiny” and for “taking the leadership role that he did. When faced with adverse media scrutiny, he remained in the spotlight and was permitted to successfully turn the tables.”<sup>35</sup> Dr. Feldman commented positively on the decisions made by HUSAR/TF3 and the machinery available during deployment. He felt that HUSAR/TF3 had made sound, rational, well-informed, and safe decisions regarding rescue efforts, something that “should be conveyed to any public inquiry.”<sup>36</sup> He also felt that HUSAR/TF3 had the right machinery during deployment and that the team did not make any mistakes by ordering it too late:

The heavy machinery (despite media reports that it should have been brought sooner) was suitable mainly for demolition and recovery, not for the sensitive first hours with signs of life in the rubble.<sup>37</sup>

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\* Exhibit 7816. Mr. Strapko also made suggestions related to laundry, clothing, and hygiene.

In terms of areas for improvement, Dr. Feldman suggested more openness with respect to signs of life. He felt people's expectations could have been better managed by letting them know of the belief that "most or all victims have died." This was something he felt was not well conveyed: "[T]he media might have concluded our decision-making was sound given our realistic assessments of survivability."<sup>38</sup>

**Dr. Feldman felt the operational leadership should have stayed in the command tent and that the local fire chief, mayor, or media relations people should have been in front of the cameras: "Bill was doing two jobs, when one would have been more than enough work for him."**

Dr. Feldman also made suggestions about media relations and operations. He felt the operational leadership should have stayed in the command tent and that the local fire chief, mayor, or media relations people should have been in front of the cameras: "Bill was doing two jobs, when one would have been more than enough work for him."<sup>39</sup> During testimony, Staff Insp. Neadles agreed with this assessment. He took on roles that did not normally fall to him such as planning officer and media spokesperson. He agreed this overload affected his ability to act as team commander, including during the crucial period from 1:20 p.m. to 3:00 p.m. on June 25.<sup>40</sup>

Dr. Feldman alluded, as well, to potential improvement in the area of medical supplies and medical staffing. With respect to supplies, he cited the fact that HUSAR/TF3 did not have the materials necessary to treat crush injuries during the deployment and had to acquire them from the local hospital:

Medical supplies: subject to further discussion. You know my thoughts about what we have to keep ready, and we were lucky the hospital replenished our supplies of expired saline and sodium bicarbonate (needed for crush injuries). Will keep working with you on this.<sup>41</sup>

In terms of staffing, he noted that HUSAR/TF3 was "down one or two physicians right now." He suggested training new physicians in order to be certain of filling spots on future deployments.<sup>42</sup>

## HUSAR/TF3 views during testimony on areas for improvement

HUSAR/TF3 members who testified were often asked their opinion on what went right and what went wrong during the deployment. Those viewpoints are summarized in this section.

### Staff Insp. Neadles's suggestions for improvement

Staff Insp. Neadles told the Commission he saw room for improvement in the areas of planning, record-keeping, and clarifying the command relationship between UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) and HUSAR/TF3.

Staff Insp. Neadles felt that HUSAR/TF3 had not done a good job in capturing what the team did in terms of planning during the deployment. He agreed that it was a mistake not to have allocated a specific person to the position of planning chief. Division Chief Doug Silver was the only person trained to occupy that position, and he did not deploy. HUSAR/TF3 was "moving towards training more people" for the planning chief position but, at the time of the Inquiry, that process had not yet begun because it involved first finalizing a course on the topic that was being developed in Manitoba.<sup>43</sup>

Staff Insp. Neadles agreed that the planning chief position was important for more reasons than simple record-keeping. The planning chief is also expected to look ahead to next steps – to assist the head of HUSAR/TF3 in that respect. Hence, deploying without a planning chief was a significant deficiency.<sup>44</sup> Without one person holding the position, responsibility for planning was spread out among different people:

Well, a lot of it rolled up into the responsibility that myself and Mike McCallion took on as the Site Commanders, and some of it took on a role with Tony Comella. He was also tasked with doing some of the planning, and that was just the action plan part of it.<sup>45</sup>

Moreover, although these three individuals allegedly occupied the planning chief position jointly, nobody was assigned the function of keeping a documentary record of the incident, despite HUSAR/TF3 having a cache of forms available for that purpose. Staff Insp. Neadles agreed that the purpose of a good documentary record was not only to look back on the incident after the fact, but also to facilitate a smoother operation during deployment:

Q. And why don't you explain to the Commissioner what the purpose beyond having a documentary record that can be looked at months after the fact, but during the deployment, what is the purpose of documenting all of these things?

A. Well, when you change operational periods, it allows the new shift to come on and the rescue squad manager, whoever is in charge of that group of men, would then be able to come to the – to the command tent and find out exactly what has been transpiring both inside that hot zone and potentially outside of that hot zone, so they have got a good – a good picture of what has actually transpired and now with getting their objectives and strategies and tactics – or they would develop the tactics for the going forward to the next operational period for their team to work on.<sup>46</sup>

Staff Insp. Neadles also gave his opinion on how to improve the working relationship between UCRT and HUSAR/TF3. He seemed generally to support the creation of a memorandum of understanding (MOU) governing the relationship and believed that such a process, involving Capt. Comella, was under way.<sup>47</sup> At the time of testimony, his understanding of the UCRT/TF3 command relationship was that OPP UCRT would be in charge during the first operational cycle. Once HUSAR/TF3 was on the scene and operational, UCRT would fall under HUSAR/TF3's overall command. He agreed, though, that not everyone understood the relationship in the same way:

I am going to qualify it to say I understand it as that ... There may have been some misunderstanding of that, because I know some of the OPP members on the ground I think have only come on the team since Trillium and may not be familiar with that. I don't know. But that is the standard process.<sup>48</sup>

Staff Insp. Neadles even conceded that there was confusion within his own team as to the proper command relationship with UCRT. It was pointed out to him that Capt. Comella's evidence contradicted his own. Capt. Comella's expectation at Elliot Lake was that the command structure was a unified command with a leader from all responding agencies. UCRT, said Capt. Comella, would have a command position equivalent to HUSAR/TF3. Staff Insp. Neadles first agreed that he and Capt. Comella had a different understanding of the command structure for joint TF3/UCRT deployments. He then backtracked, suggesting that Capt. Comella might be referring to Chief Paul Officer's level of command, but that, for the whole rescue, "somebody has to make that decision, which is HUSAR." When pressed further, though, he again agreed there was a conflict between what he and Capt. Comella understood the command structure to be.<sup>49</sup>



## Cmdr. McCallion's suggestions for improvement

Cmdr. McCallion saw room for improvement in the areas of communications, planning, and documentation.

Cmdr. McCallion thought that communications between the OPP and the command tent could have been improved, although he seemed to attribute fault to the OPP's failure to properly staff its team:

I feel Sergeant Gillespie was – I'm trying to think how to put this as nice as possible – I think Sergeant Gillespie was overtasked. He was under-resourced. I think he admits he was under-resourced. He only had, I believe, 10 or 12 of his staff there. He was wearing multiple hats and there was no support for him in the Command tent, so I think that – and he had a team of A personality members, some with experience, some with very little HUSAR experience. And I think maybe, in some cases, they were pushing him to make decisions or to get information that he maybe should have gotten or feels he should have gotten in a different manner?

So I think that that communication with Sergeant Gillespie could have been improved on.<sup>50</sup>

Cmdr. McCallion also mentioned a "personality clash" between himself and Sgt. Jamie Gillespie. He wished the two could have discussed the matter since, but then conceded that he personally had not reached out to Sgt. Gillespie.<sup>51</sup>

In terms of media relations, Cmdr. McCallion agreed with the suggestion that HUSAR/TF3 needed a designated media officer: "I think it's important to tell people what you are doing as you do it."<sup>52</sup> Cmdr. McCallion thought that documentation during the deployment could have been improved and, like Staff Insp. Neadles, indicated that if a deployment were to occur today, he would immediately designate someone as planning officer in order to have a scribe and to ensure the proper forms (such as incident action plans and scene assignments) are filled out.<sup>53</sup>

## Capt. Comella does not see areas for improvement

Capt. Comella, when asked, was reluctant to suggest that, from the HUSAR/TF3 perspective, anything had gone wrong during the Elliot Lake deployment. He thought that the team "did everything well" and said that he did not know if he could "identify something that was wrong or less efficient."<sup>54</sup>

In the end, he did suggest that communications could be improved: "I guess there was always room for improvement with everything, but I couldn't necessarily pinpoint any particular thing that I would focus on. Communications is always an issue. Better communications, whether that be from a Unified Command cell down."<sup>55</sup> When pressed, he also conceded that it was a problem that he, given his rank, was unaware of the nature of Staff Insp. Neadles's decision to stop – that is, whether the operation would continue as a rescue or as a recovery.<sup>56</sup>

## Suggestions for improvement from other HUSAR/TF3 members

Other HUSAR/TF3 members who testified made suggestions for improvement in the areas of planning and documentation, note-taking, HUSAR/TF3 self-sufficiency, media relations, and site security.

Capt. McRae felt that HUSAR/TF3 needed more people trained as planning chiefs. He pointed out that the team already had training on report-writing and the use of forms as part of the planning process, and he seemed to suggest that it simply needed to be better implemented. He also suggested the use of digital recorders for note-taking, pointing to the fact that, in Elliot Lake, it had been difficult to keep notes dry when it rained.<sup>57</sup>

Sgt. Glavin personally would have liked to have kept better notes during the deployment. He thought the response would have been better if a larger HUSAR/TF3 team had deployed. He also felt HUSAR/TF3 should have stuck to the “whole concept of our tent village” – that it should have been more self-sufficient on site. He did not think it would have slowed them much to have brought the additional trailer with tents. He described the negative consequences of having the team scattered about town:

As it turned out, we had people scattered all over town. There were some in apartment buildings. Some were in the hotel. Some weren't.

I had the pleasure of the first two nights I got to sleep in a bed, and then after that I slept in the cab of my truck.

Had we set up our tents, that's where you start, and if you had to rally another response team quickly, you go back to a tent and you wake them up ... you [shouldn't] let your team members out into the general populace; you kept them together.<sup>58</sup>

Sgt. Glavin expressed great confidence in Staff Insp. Needles and Cmdr. McCallion, and in his team members. When pressed on whether a Plan B should have been in place earlier, given his earlier evidence that it was clear the building was moving, he conceded that earlier consideration of a Plan B would have been prudent, and he appeared to agree that the team needed a planner on board.<sup>59</sup>

Capt. Chuck Guy thought, on the positive side, that HUSAR/TF3 worked “flawlessly in the tasks that they were given.” He saw room for improvement in terms of “accountability for some of our members.” He referred to one occasion where two members walked from the hotel to the food area, at about the time that the crowd had gotten angry. He thought that if they had run into the crowd, it could have been a big problem. Although it was unusual in Canada to have to worry about the security of the members, he felt that, in the future, HUSAR/TF3 should stick to its ordinary training scenario, which involves setting up camp in a secure area and working in proximity.<sup>60</sup>

## **The Ontario Provincial Police and UCRT do carry out after-action assessment**

### **UCRT meets for a debriefing on July 4, 2012**

UCRT held a debriefing on July 4, 2012. Sixteen members were present, seven of whom were not actually deployed to Elliot Lake. These individuals were Acting Insp. Wayde Jacklin, Staff Sgt. Jim Bock, Sgt. Mike Dolderman, Ad Ferrao, Chuck Reavie, Matt Young, and Sgt. Meshach Parsons. The other nine had deployed. These were Csts. Dan Bailey, Mick Belgum, Brandon Boles, Chris Collins, Ryan Cox, Martin Groleau, Steve Hulsman, Tim Sobschak, and Paul Weber. Sgt. Gillespie, Cst. Patrick Waddick, and Cst. Marc Walsh were not present, despite having deployed.<sup>61</sup>

Following is a summary of some of the perceived positives and points for improvement for the Elliot Lake deployment, as reflected in the minutes of the July 4 debrief.<sup>62</sup> While many points for improvement are mentioned, the most consistent theme was the lack of command and control presence from the OPP perspective, and the difficulties this situation created. Acting Insp. Jacklin confirmed this assessment and told the Commission that, from the OPP perspective, Sgt. Gillespie was multi-tasked. Someone at a higher rank was needed for this deployment to ensure that UCRT's needs were being met at the “big table.”<sup>63</sup>

### Acting Insp. Jacklin's perspective

Acting Insp. Jacklin made these observations:

- *Ordering the crane.* The crane, requested en route by Cst. Cox, was supposed to be on site by midnight but did not arrive until the next morning.
- *Food and housing.* UCRT had to wait for a restaurant to open before the team members could get food and, until the Office of the Fire Marshal found a closer hotel, UCRT hotel rooms were an hour away. He suggested UCRT should bring tents next time.
- *Relations with HUSAR/TF3.* He expressed frustration with HUSAR/TF3, saying "CTF-03 was to work with UCRT but did [their] own thing."
- *Command and control.* He expressed frustration over a lack of OPP UCRT command and control. He recognized that he should have been on scene and suggested that UCRT needed a Level 2 incident commander (discussed below) to attend similar scenes in the future.
- *Problems with the dogs.* The cadaver dogs wouldn't go onto the pile without a lead, and so there was a need to train cadaver dogs to search off lead. In testimony, he advised that he has already attempted to implement this training.<sup>64</sup>

### Sgt. Dolderman's perspective

Sgt. Dolderman made these observations:

- Local OPP command (Insp. Percy Jollymore) was not aware of UCRT capabilities and lacked the capacity to order equipment quickly.
- There should have been an OPP incident command post in place to assist with providing proper information to the media.
- The OPP had difficulty maintaining control and communicating between teams given the absence of a unified command structure.

### Staff Sgt. Bock's perspective

Staff Sgt. Bock made these observations:

- *Financial issues.* He referred to financial pressures but indicated that, once a state of emergency was called, "money was released."
- *Command and control issues.* He felt UCRT did not have a "Command or Control" presence, and he needed to ask for a "2 IC" (Level 2 incident commander) specific to the UCRT team in future deployments.
- *Food, housing and logistics.* He referred to problems UCRT experienced in finding food and suggested UCRT may have needed better logistics assistance.
- *Lack of radio contact.* He referred to a lack of proper radio contact with the "command post," which he thought should not have been at the local detachment but on site, and said: "Every team seemed to be on different radio channels, no communication between them."
- *Relations with HUSAR/TF3.* He considered that HUSAR/TF3 needed to apologize to UCRT for the way the team was treated.



### Cst. Collins's perspective

Cst. Collins made these observations:

- He referred to the crane having “sat a full day before using.”
- He also felt the HUSAR/TF3 workers were helpful and professional, but the “team leaders were not professional.”

### Cst. Bailey's perspective

Cst. Bailey made these observations:

- *Command and control.* He expressed frustration over the absence of a “structured command.” He felt that “[a]ccountability seemed to be in the OFM tent with CTF-03” and felt there were too many HUSAR/TF3 “chiefs on the pile giving orders.”<sup>65</sup>
- *Rescue aborted too soon.* He felt that a person could have been pulled out of the pile on Day 2 “if [his team had been] allowed to do so with equipment on scene as requested and stayed to original plan.”
- *Local OPP command was not aware of UCRT capabilities.* He felt that the OPP command post did not understand UCRT capabilities.
- *Lack of radio contact.* He said communication was poor and that everybody was on different radio channels, making it a safety issue. He felt HUSAR/TF3 should have provided radios, a recommendation he reiterated during testimony.<sup>66</sup>
- *Media relations.* He felt the OPP should have had its own media person on site. HUSAR/TF3 should not have spoken on their behalf.

### Cst. Cox's perspective

Cst. Cox made these observations:

- *Note-taking.* He felt that people were multi-tasked and therefore too busy to take notes.
- *Command and control, and poor relations with HUSAR/TF3.* He expressed frustration with HUSAR/TF3 command, suggesting things went smoothly for the first 15 hours – until HUSAR/TF3 started “calling shots.” He referred to “constant battles” with HUSAR/TF3 and expressed disappointment that HUSAR/TF3 got credit for work done by UCRT. During testimony, Cst. Cox added that Sgt. Gillespie was stretched too thin and UCRT was not included in planning decisions.<sup>67</sup>
- *Good engineering assistance.* He felt the engineers were great and did not hamper the mission.
- *Food and housing.* He also mentioned that UCRT was “hungry one night.”

### Cst. Hulsman's perspective

Cst. Hulsman made these observations:

- *Relations with HUSAR/TF3.* He said the team was “disappointed that they were bullied out of the way by CTF-03.” In testimony, he relayed his impression that HUSAR/TF3 felt they could have done without UCRT.<sup>68</sup>
- *Housing.* He pointed out that only half of UCRT's team was able to go, and that the tent trailer did not go with them because of a lack of numbers. In testimony, he explained that the tents, if they had been brought, would have provided sleeping quarters for UCRT if no hotels were available; and he would have placed them closer to the scene, assuming there was room at the scene to camp.<sup>69</sup>

- *Command and control issues.* He stated that the ground workers for HUSAR/TF3 and UCRT worked well with each other and everybody worked very hard. His perception was that the command structure wasn't functioning properly.
- *Shoring and rigging.* He thought that the shoring was well done, despite having to adjust to higher ceilings. The crane rigging, which UCRT carried out side-by-side with HUSAR/TF3 members, went "exceptionally well." No one was injured.<sup>70</sup>

## Sgt Gillespie creates a brief after-action report on July 12, 2012

Even though he missed the July 4, 2012, debriefing, Sgt. Gillespie wrote a brief after-action report on July 12.<sup>71</sup> Like his UCRT colleagues, he criticized HUSAR/TF3 command and control during deployment, while being generally positive about UCRT's actions, stating:

Extensive command and control issues were encountered throughout the operation with CAN TF3 leadership. UCRT members responded quickly and worked in a very professional manner throughout the rescue phase with no significant deficiencies [sic] in equipment or training to conduct this work.

...

UCRT members worked extremely well together and with CAN TF3 members but were extensively hampered in their efforts by CAN TF3 commanders.<sup>72</sup>

Sgt. Gillespie retreated from this criticism of HUSAR/TF3 command during testimony. He called the comments in his report an "overstatement." He still felt he should have been more involved within the command and control structure, but agreed that he did not suggest this belief to HUSAR/TF3 leadership during the deployment because he preferred to "stay with my members and keep them safe."<sup>73</sup> He attributed his general frustration to a lack of OPP resources:

I think I was just overly frustrated with not having the proper support there, from our own organization as well as the issues that we spoke about earlier. So, when I say it's an overstatement ... it is exactly that. It's – you become far too emotionally involved in these things ... It's a regret on my part that I wrote it in that fashion but it is what it is. I've written it that way and I have to account for that.<sup>74</sup>

## The OPP Field Support Bureau creates a comprehensive after-action report

The Ontario Provincial Police Field Support Bureau created an after-action report in relation to the overall OPP involvement at the Algo Mall collapse. The Commission's copy is not signed or dated, but is noted as having been submitted by Asst. Supt. Geoff Edwards (director of the Field Support Bureau) and approved by Chief Supt. Robert Bruce (commander of the Field Support Bureau) and Deputy Commissioner Larry Beechey (provincial commander).<sup>75</sup>

The report is divided into six parts:

1. [B]ackground and Chronology of the Event
2. East Algoma Detachment
3. North East Region (RHQ/EOC)
4. Field Support Bureau – UCRT
5. Incident Command
6. Field Support Bureau – EMU (Emergency Management Unit)<sup>76</sup>

Each part includes an overview, along with sections on best practices (defined in the report as actions that were considered beneficial and recommended for future events), lessons learned (which the report defines as action or inaction that was not beneficial to the overall operation), issues, and recommendations.<sup>77</sup>

It is necessary to summarize in detail only the conclusions relating to the East Algoma detachment, UCRT, and incident command. The section on the Emergency Management Unit mentions that “Mobile One” (a mobile Emergency Operations Centre, or EOC) was eventually deployed by the OPP to the Elliot Lake scene and recommends that “thresholds” be established for the activation of EOCs in the future.\* The section on the North East Region did not raise issues directly related to improving the rescue and recovery operation.<sup>78</sup>

### Recommended areas for improvement for the East Algoma detachment

With respect to the East Algoma OPP detachment that policed Elliot Lake, the report saw the detachment’s continued involvement with the Community Control Group as something positive and recommended continued participation in scenario-training on that front. In terms of areas of improvement, the report cited issues related to perimeter security, media relations, and logistics.<sup>79</sup>

The report cited difficulty securing the scene when it became necessary (presumably when the rescue was called off):

One lesson regards site supervision in relation to when to disengage from rescue and focus on scene security. Front Line Supervisor had difficulty with that issue[.]<sup>80</sup>

Logistical problems ensued as more and more OPP resources were deployed to the scene, among them:

- Influx of OPP human resources became logistical problem for accommodations and meals.
- No staging or mustering area. Needed a place where site commander could muster crowd control units.
- Limited space availability for command functions.
- Resource requirements and management, resources like Mobile Command Post 1 was sent however because of the scene there was no place to deploy it ... It wasn’t until Monday, June 25th that a secure area inside the perimeter clear for deploying the Mobile Command Post.
- Meals and accommodations were not a major issue until Sunday at which time, as a small community, food and rooms for attending resources became a major issue. In place of everyone managing their own units, all of this needed to be coordinated through the Municipal Group. This would have saved a lot of time and frustration for all parties involved.<sup>81</sup>

The OPP recommended that the East Algoma detachment could have benefited from logistics management training, even though the OPP was not in charge of what was termed a “Municipal Emergency.”<sup>82</sup>

**Meals and accommodations were not a major issue until Sunday at which time, as a small community, food and rooms for attending resources became a major issue.**

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\* Exhibit 7784, pp. 021–3. The report also recommended development of standard operating procedures for “Region / Division EOCs,” the need for Region / Division EOCs to conduct a provincial exercise including all locations, and the need for sharing contact information among regional EOCs.



## Recommended areas of improvement for UCRT

According to the report, tactical operations went “very well from a UCRT perspective,” but several challenges arose.<sup>83</sup>

In terms of best practices (defined in the report as actions that were considered beneficial and recommended for future events),<sup>84</sup> the report considered UCRT’s actions to have been positive on numerous fronts:

- *Rapid deployment.* UCRT deployed all available members and resources “very efficiently” and was able to have “the broadest ranges of the unit’s capabilities to the scene even though the overall number of responding members was quite low.”
- *Quick to develop a plan.* UCRT quickly assessed structural stability and developed immediate and alternative action plans even before arriving on scene – by looking at photographs, figuring out victim information and suspected location, and understanding the type of structure and the potential scale of the rescue operations. “Acquisition of external logistics such as heavy crane equipment and wood shoring was organized before arrival.” Rescue efforts began shortly after arrival.
- *Well trained and worked relentlessly.* UCRT’s extensive training enabled responding members to begin rescue operations in this very complex scene. The work environment was described as difficult, but “[a]ll deployed members from UCRT worked tirelessly to accomplish the tasks assigned to them, including working extended hours with minimal rest periods.” UCRT efforts were described as “professional and safe ... [as] recognized by the Ministry of Labour (MOL) inspectors assigned to this incident as overall safety oversight.”
- *“Worked seamlessly with most partner agencies.”*
- *Communication strategy was “successfully implemented.”* The detachment commander was aware of the UCRT mandate, and call-out protocols were followed “perfectly” through the OPP chain of command.<sup>85</sup>

In terms of “lessons learned,” which the report describes as action or inaction that was not beneficial to the overall operation,<sup>86</sup> the OPP saw room for improvement for UCRT in the following areas:

- *Availability of non-commissioned officers (NCOs).* Only one of the four UCRT NCOs was available to respond directly to the scene, which resulted in “multi-tasking of unit level Incident Command responsibilities.” This problem was compounded by the need for “continuous 24 hour based rescue operations” and continuous input from UCRT command to the overall incident command. The OPP recommended that, in the future, it would be “critical” that leadership gaps be filled.<sup>87</sup>
- *OPP incident command was overtasked and not able to oversee UCRT operations.* The OPP determined that the incident commander, Insp. Jollymore,<sup>88</sup> was not able to dedicate sufficient time to overseeing detachment commander duties, incident command from a detachment perspective, and direct command of the tactical rescue operations headed by UCRT, “specifically the NCO complement that would be responsible for direct UCRT command.” The perceived result was the creation of logistics issues and the overtaking of control by HUSAR/TF3:

As a result of the shortfalls in OPP Incident Command, this function was directly taken over by an external partner agency and the OPP resources directly involved in the rescue efforts had little to no direct input into the command of this incident. This also created a deficiency in getting heavy equipment and needed resources for the rescue in a timely manner.<sup>89</sup>

- *UCRT’s relationship with HUSAR/TF3 was strained and affected the rescue.* The report found that a strained relationship between UCRT and HUSAR/TF3 caused difficulty when it came to “the common goal of assisting those injured and trapped.” The difficulty, according to the report, related to HUSAR/TF3 command and the aforementioned “deficiency in the OPP command and control presence.” The report states that HUSAR/TF3

took over tactical control from the Elliot Lake fire chief, who had been following the Incident Management System (IMS), and the following leadership difficulties ensued:

- UCRT was not permitted access to command briefings or input into the rescue operations;
- information flow between UCRT and HUSAR/TF3 was “next to none”;
- UCRT received “misinformation” from HUSAR/TF3 (not specified); and
- The OPP felt that the UCRT members were as well trained as the HUSAR/TF3 members and that the only difference between the two teams was the amount of members available:

Both units are comparably trained and capable of completing identical tasks with the exception of the number of personnel that are capable of responding. CAN TF3 was requested at the outset of the incident due to the limited personnel that were available to respond to this incident from UCRT.<sup>90</sup>

Insp. Jollymore was asked about the comment in the report that, because there were shortfalls in OPP incident command, the function was taken over by an “external partner agency” such that the OPP had little direct input into the command of the incident. He saw this role as an indication that UCRT was reluctant to play the role of a mere support agency, but instead wanted its own incident command at the scene. He saw this attitude as going against the IMS concept:

Well, what this tells me, that even though UCRT is trained in IMS training, that they are not accepting the fact that they fall under that umbrella as a support service in this particular case. They are not accepting that. They are talking about having their own Incident Commander take over the entire incident.<sup>91</sup>

In fact, Insp. Jollymore disagreed with the general thrust of the report. It seemed to him that the OPP wished in the future to take complete control, as opposed to adhering to the IMS structure of incident management.<sup>92</sup>

Sgt. Gillespie was also asked about this section of the report, in particular the OPP assertion that “UCRT was not permitted access to command briefings or input into the rescue operations.”<sup>93</sup> He testified that this was how UCRT perceived the situation at the time, although he also said no evidence existed to support the assertion:

A. That’s how it was perceived at the time. I wouldn’t say there was any evidence to say that they were not permitted, but it would seem that on the first – return to the first shift on the evening of Sunday night ... I asked [on] a couple of occasions when the next command briefing would be and it would be continually put off, so I don’t know the answer for that, to this day.

Q. In your opinion, was that exclusion intentional or just a result of UCRT not having someone in the command centre?

A. I think it’s both.

Well, I shouldn’t say “both,” but it felt like it was intentional at the time. I don’t know that it was, but it certainly contributed to the fact that we did not have anybody there staffing it.

That certainly contributed to the information flow problem that was identified there.<sup>94</sup>

The OPP then made several recommendations with respect to UCRT, many of which relate to strengthening the command structure during future deployment. Among them:

- The UCRT unit commander staff sergeant or delegate should attend every “critical scale incident” assigned to UCRT.
- A minimum number of NCOs should be created within UCRT to respond to incidents.
- When certain NCOs are unavailable, they should be replaced in an acting capacity by appropriately trained members, and they should not be multi-tasked with other incident responsibilities. If such members are not available within UCRT, they should come from elsewhere within the OPP and “have the skills and abilities to perform these duties” and be familiar with the UCRT mandate and operating procedures.

In the area of incident command, the report called for an inspector to be the UCRT program manager and for the mandatory involvement of a critical incident commander as direct incident commander of UCRT resources:

1. Establish policy that initiates the mandatory involvement of level one or level 2 Critical Incident Command for direct Incident Command of UCRT resources at appropriate scale based on the circumstances of the incident.
2. Establish the Inspector program manager of UCRT as an Incident Commander for these incidents. This commissioned officer is very familiar with the UCRT capabilities, personnel, and standard operating procedures.<sup>95</sup>

Sgt. Gillespie explained in testimony that it was his recommendation to Acting Supt. Edwards that the OPP put critical incident commanders into the command position for large-scale USAR and CBRNE incidents. He explained that critical incident commanders have more training than incident commanders: "It's the higher level of training for incident commanders within the OPP."<sup>96</sup> Based on his observations at the Elliot Lake scene, Sgt. Gillespie felt that a critical incident commander would have had more experience in running large-scale incidents, and potentially a better understanding of needs and capabilities. The overall result would be a greater OPP presence at the command centre and better access to information.<sup>97</sup>

The report then made recommendations related to issues such as note-taking, rigging and crane operations, debriefings, and further training. These included:

- expanded training to more members of UCRT in rigging and crane operations;
- ensuring that post-incident debriefing sessions are conducted with as many members present as possible among those who attended the scene, especially those of critical importance to the operations phase;
- creation by UCRT of a critical incident note-taker or scribe position;
- training for incident commanders on how a state of emergency is declared and how resources are paid for. The use of two heavy cranes during the Elliot Lake rescue effort was cited as an incident showing that incident commanders require more information on how to deploy such resources:

Educate existing Incident Commanders in the areas of CBRNE and USAR and the role / needs of UCRT in such incidents. Specific to incident two heavy cranes were critical to the rescue effort and were requested immediately. While these items are very costly to acquire, knowledge of how a declared state of emergency and how these resources are paid for at the end of the incident would have been beneficial for the Incident Commander making this decision.<sup>98</sup>

The report also made recommendations on "External Relationships." Again, emphasis was placed on the OPP maintaining a command and control presence in future events. The recommendations include:

- a formal debrief with HUSAR/TF3 and UCRT command level members present;
- maintenance of command and control of incidents of this nature by "initiating a strong and continuous OPP incident command presence with local officials"; and
- development of a linkage between UCRT and the Criminal Investigation Bureau (CIB) early on, to "ensure UCRT members [have] knowledge of critical pieces of evidence ... and ensure that they are secured during the demolition phase and protected."<sup>99</sup>



## Recommended areas of improvement for “command and control” for overall OPP presence at Elliot Lake deployment

Despite having canvassed the issue to a great extent in other sections of the report, the OPP dedicated an additional section to assessing issues of command and control related to the Elliot Lake deployment. Again, the focus was on maintaining a strong OPP command presence for future deployments.

The report painted a picture of confusion over who was in command during the Elliot Lake deployment:

The event was being managed by a detachment commander [Jollymore] [who] took on the role of Incident Commander. There were two Level 1 Incident Commanders on site for this event, working days and nights. Upon discussion with both day and night commanders it was clear that roles and responsibilities were not identified or known to commanders. Day and night commanders assumed they were responsible for arranging personnel for access points and logistics – something done by a logistics officer. An inspector detachment commander was overall lead and both day and night Incident Commanders were S/Sgt's. No Incident Command organization and the command post at the time was an NCO office in detachment along with a small boardroom.

Level Incident Commanders did not know HUSAR mandate or how they fit in the response / command and control triangle. On site Incident Commanders did not have established roles and responsibilities, the host detachment commander assuming overall command and of Town, site and exterior issues caused an issue as he was not available or on site most of time. Incident Commanders not readily identifiable at the scene (lots of white shirts walking around), Incident Commanders did not have proper protective equipment to be on site (hard hat, safety toes).<sup>100</sup>

The OPP therefore made the following recommendations with respect to command and control:

- ensuring that incident commanders are familiar with and educated about incident command and unified command;
- reorganization of incident command and major incident response procedures for similar events in the future. This reorganization would include properly trained incident commanders – “trained to today’s standards and ... familiar with OPP resources” and establishment of an OPP emergency response presence “from day one at the scene and not 4 days later”;
- development of regional training sessions with “regionally identified incident commanders” for events that require UCRT;
- proper supervision of incident commanders to establish who they are accountable to;
- involvement of the Field Support Bureau to take control of large-scale events and become more involved in operations and deployments;
- creation of a running log of agencies and support members at the scene;
- creation of a questionnaire or similar document to allow officers and supporting agencies to provide recommendations at the scene:

A simple form with drop area can make us more efficient in dealing with these things in the future, lots of officers and supporting agencies probably have ideas which we will never hear or learn.

- provision of equipment to incident commanders and a better way to identify them at the scene, beyond just a “traffic vest or armband.”<sup>101</sup>

## OPP Chief Supt. Bruce recommends strengthening the OPP command presence in future deployments

Chief Supt. Bruce, who approved the OPP after-action report, was, at the time of his appearance before the Commission, the commander of the OPP's Field Support Bureau. Although in his testimony he did not comment directly on the after-action report, he did discuss areas for OPP improvement following the Elliot Lake deployment. He provided suggestions for improving UCRT/TF3 co-operation through training, but focused mainly on strengthening the OPP command presence in future deployments involving UCRT.

On the topic of UCRT/TF3 co-operation, Chief Supt. Bruce favoured the creation of a memorandum of understanding covering UCRT/TF3 collaboration during future deployments.<sup>102</sup> He also suggested that the two agencies should engage in joint training as an opportunity, among other things, to address any past frictions. He pointed to the fact that the OPP worked "seamlessly" with HUSAR/TF3 when deployed to Goderich.\*

Chief Supt. Bruce also explained the OPP's desire to improve the command structure for future deployments like Elliot Lake.<sup>103</sup> It is unclear from his evidence, though, whether he wanted the OPP to be subordinate to, equal to, or in charge of the rescue operation should HUSAR/TF3 and UCRT deploy together in the future.

First, he explained the incident command structure within the OPP. The OPP has a range of incident commanders: incident commanders, critical incident commanders, Aboriginal critical incident commanders, and public order commanders. A critical incident commander must be above the rank of staff sergeant, already be a first-level incident commander, and have successfully completed a 20-day course and mentoring program. A critical incident commander would typically be contemplated for high-risk incidents involving an integrated OPP response (multiple OPP units working as one). He gave the example of a hostage-taking.<sup>104</sup> Regular incident commanders, on the other hand, need the minimum rank of sergeant, but can be of any rank above that. Incident commanders take a 10-day course and are involved in any incident considered a "major incident," defined as involving the use of resources beyond local detachment capabilities.†

Chief Supt. Bruce then explained that, for future events like the Elliot Lake collapse and rescue, a "Unified Command structure" needs to be created with a "major Incident Commander" with overall command "so that ... every agency is represented by their Incident Commander and reports down through their chain" with the "overall Incident Commander ... responsible for the overall operation."<sup>105</sup> He did not specify who would be the overall incident commander but seemed to suggest that it would depend on the nature of the deployment. He provided the example of the 2002 World Youth Day in Toronto to explain his preferred command model. At that event, given the presence of an internationally protected person, the RCMP had an incident command to protect the Pope. However, the Pope passed through many jurisdictions (including Toronto Police and OPP). In those instances, according to Chief Supt. Bruce, the command structure was a unified command but with ultimate decisions being made by the RCMP:

[O]ur Incident Commanders would run a section and report to us, but the decisions at the end of the day, once we have had our input, will be made by the RCMP, whoever that Incident Commander is."<sup>106</sup>

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\* Bruce testimony, August 23, 2013, p. 22145. In August 2011, a tornado caused the structural collapse of a warehouse in Goderich. An individual was killed and needed to be recovered: Gryska testimony, September 23, 2013, pp. 26677–8.

† Bruce testimony, August 23, 2013, pp. 22139–40. The Aboriginal critical incident commander would have the same requirements as the critical incident commander, along with greater familiarity with Aboriginal issues. The public order commander would be staff sergeant or higher and would have training and certification related to public order events, typically crowd control and big demonstrations. See also Exhibit 841, which provides a description of OPP "Major Incident Command." That document does not, however, reflect the recent changes to incident command mentioned by Chief Supt. Bruce: Bruce testimony, August 23, 2013, p. 22154.

Later in his testimony, Chief Supt. Bruce again attempted to explain his idea of an ideal command structure in the context of a “unified command.” It was again not clear from his evidence whether he felt the OPP would have overall command of an Elliot Lake–type deployment, a shared and equal command with an entity such as HUSAR/TF3, or a role subordinate to it. He seemed to recognize that in Elliot Lake, Chief Officer was the overall incident commander, but this opinion, again, was not clear from his evidence.<sup>107</sup>

What is clear, however, is that the OPP intends to beef up its own command presence for any future UCRT deployments. Chief Supt. Bruce said there have been changes implemented as a result of lessons learned at Elliot Lake. When UCRT is deployed in the future, an inspector in emergency management will deploy with them as incident commander. Structural collapses are now categorized as high-risk events (where they would have been only major incidents before) such that a critical incident commander must be assigned. This role, he said, would allow the local police to focus on local issues while the critical incident commander focuses on the overall rescue operation.<sup>108</sup> He pointed out that, for the Elliot Lake deployment, a staff sergeant should have held the UCRT command but, in fact, Sgt. Gillespie was the highest-ranking UCRT officer present, something he described as a failure on his (Chief Supt. Bruce’s) part to ensure a proper command structure. With the new changes, a staff sergeant would be unit commander for UCRT, with a person of higher rank in the position of overall OPP incident commander.<sup>109</sup>

**When UCRT is deployed in the future, an inspector in emergency management will deploy with them as incident commander. Structural collapses are now categorized as high-risk events (where they would have been only major incidents before) such that a critical incident commander must be assigned.**

Four incident commanders have already received additional training, at the Level 2 command level, on how UCRT works. A commander trained to this level, and with this knowledge of UCRT, will be deployed at the next event of this nature.<sup>110</sup>

Chief Supt. Bruce said this new command structure, for future deployments of a similar nature, would also solve the problem (mentioned in the after-action report) associated with a perceived lack of support for the detachment and for Insp. Jollymore, whom he referred to as the incident commander. He pointed out that Insp. Jollymore would not have had intimate familiarity with UCRT capabilities. In the future, a critical incident commander would have that familiarity.<sup>111</sup> Chief Supt. Bruce later added that he felt the crane might have been ordered sooner if the UCRT unit had an inspector as incident commander and that person had ordered the crane. The UCRT inspector, unlike Insp. Jollymore, would already have known how to access that resource without having to research the matter.<sup>112</sup>

In summary, Chief Supt. Bruce thought that command, control, and communications could have been improved at the Elliot Lake scene. Although he felt the result would have been the same from an operational perspective, the OPP’s suggested improvements to command and control “would have put people in the right positions ... it would have had the elements that were there properly represented at [the] command table. That would have limited or eliminated a lot of confusion as far as the communication and things like that.”<sup>113</sup>

In keeping with the OPP’s focus on perceived failings in establishing a command presence, Chief Supt. Bruce also felt that media relations would have been improved with a stronger command and control structure:

I think when you have a very good command and control structure, the media at least will gravitate to and understand that that’s where the information should come from, and while they’ll want to ask other people, they’ll know that they can qualify it with that command.<sup>114</sup>



## The City of Elliot Lake and the Elliot Lake Fire Department

### The City of Elliot Lake fails to hold a debriefing despite a requirement to do so

The City of Elliot Lake failed to conduct a debriefing following the Algo Mall emergency response. The evidence clearly indicates that the calling of this Commission was the major impetus behind the failure to do so. As with HUSAR/TF3, I find it difficult to avoid the strong suspicion that City officials sought to avoid scrutiny of the conclusions reached in any debriefing or after-action report by the Commission or other interests.

The City of Elliot Lake was aware that a debriefing was required pursuant to its emergency response plan.<sup>115</sup> Part 8 of the plan, entitled “Phasing Out Operations & Terminating Emergency,” states:

A debriefing which will focus on the strengths, opportunities and challenges of the emergency response activities will occur within five working days of the official termination of the emergency response. Recommendations must be documented and assigned for action within a reasonable timeframe with follow-up by the CEMC [Community Emergency Management Coordinator] as appropriate. The City of Elliot Lake ERP [Emergency Response Plan] will be revised accordingly.<sup>116</sup>

The idea of holding a debriefing session did come up in July at a Community Control Group meeting, but Mayor Richard Hamilton suggested that it did not happen because there were difficulties getting people together. He insisted that the intent was not to avoid scrutiny:

[I]t was decided at that time with the Inquiry, you know, happening and such that that debriefing was probably best left until the emergency was called off.

Q. And was there a concern that the Inquiry would have the findings of any such debriefing eventually if you held it before the Inquiry was held?

A. Not in my mind, no.

Q. Anyone else's?

A. Not that I am aware of.<sup>117</sup>

Chief Administrative Officer Robert deBortoli was also aware that a debriefing was required following the conclusion of an emergency. He said, however, that, because these were “special circumstances,” the City would “debrief once everything was concluded.”<sup>118</sup> Although he did not explain what he meant by “special circumstances,” Mr. deBortoli was referred to emails between Insp. Jollymore and Trudy Rheame, the emergency management coordinator, flowing from Ms. Rheame's attempt to schedule a debriefing.<sup>119</sup> In those emails, Insp. Jollymore raises the point that, if the debriefing were held before the Inquiry, the results would need to be disclosed to the Inquiry.<sup>120</sup> Insp. Jollymore wrote the following to Ms. Rheame on July 26, 2012:

Trudy a couple of things before I respond to this. A [*sic*] hour is far to [*sic*] short. The Emergency is still in place. Just to prepare for this would take hours of time. A full review of the Emergency Plan and everyone's role, what we did and how it worked.

This is something that needs a [fair] amount of thought and review. *In addition we are all facing an inquiry, a public inquiry meaning that the findings of this would have to be available to them.*

Normally this would occur after the inquiry for the reason I have outlined. I just completed one for a Barricaded person a[n] event that was done in 4 hours and the Debrief took 2 and half hours.<sup>121</sup> [Emphasis added.]

Mr. deBortoli insisted, like Mayor Hamilton, that this possibility did not influence the decision to not hold the debrief:

No. I don't think there is anything wrong. If we had done a debrief and whatever the findings were would have been – that there would have been no issue with having that information brought forward.<sup>122</sup>

Ms. Rheume confirmed that the general practice pursuant to the emergency response plan was to have a debriefing. A debriefing was scheduled, but when it was learned that an Inquiry would take place, the decision was made to have the debriefing “later.” Referred to her email exchange with Insp. Jollymore, she told the Commission that she was directed by the CAO to postpone the debriefing:

It seemed plausible to delay it [the debriefing] because of the inquiry, and then the inquiry would most likely help out with the debriefing in providing us with answers as to what went well and what could be improved upon. And through direction from the CAO, that is what we decided to do.”<sup>123</sup>

## Suggestions for improvement from the City

At the hearings, certain City of Elliot Lake officials were asked their opinion on what went well and what could have been done better during the rescue and recovery operation.

Mayor Hamilton suggested that the City could have used more assistance when it came to media relations. He pointed to the existence of the OPP trailer that he recalled arriving on scene three days after the collapse. He called it the media control station and said the City could have used something like it earlier on. The City did not have TVs, monitors, or similar technology in its control centre. Instead, a few individuals, including Mr. Hamilton, took notes and communicated with the media via telephone.<sup>124</sup> He described the amount of work he had to do just dealing with media inquiries:

Q. Who were you called to or what media organizations do you recall being contacted by?

A. I think if I told you the ones I wasn't contacted by it would be a shorter list, quite frankly. It was – I was getting contacted by media outlets that I had no idea even existed, as far away as Houston, Texas. I was getting media inquiries from Europe, from those right across the country, all the major news chains, both television, newspapers, radio stations. And in fact, we were lining them up in ten-minute increments, and we were going for two or three or four hours at a time.

Q. Have you ever had to do that before?

A. Absolutely not. It was frightening.<sup>125</sup>

Mayor Hamilton thought more assistance on this front would have been useful for a small town like his dealing with a “big-city tragedy.”<sup>126</sup>

Mayor Hamilton and Ms. Rheume both commented on the requirement in the plan for members of the Community Control Group to keep personal logs of their activities. Mayor Hamilton told the Commission that he simply did not have the time to do so:

All I can say to that is I would be doing nothing but a log, because I was on the phone almost steady with either media outlets, with various government agencies, with various government people. I had Mayors from all over the country calling me ... I would be writing a perpetual log and actually not doing my job.<sup>127</sup>

Ms. Rheume agreed that not all members of the Community Control Group kept logs. She pointed out that these were people who did not normally attend to emergencies and were under an enormous amount of stress. Keeping a log did not come naturally. She herself tried to keep one and found that her notes were “all over the place.” She agreed, however, that notes are useful and felt there should be training on this point in the future.<sup>128</sup>

Mr. deBortoli saw little room for improvement, other than in the areas of communications and media relations. He felt, in hindsight, that everybody involved gave 110 percent and did a very good job. He saw only “minor, minor areas” for improvement, such as gaps in communication, and suggested that, in the future, the City would definitely get someone to assist with media relations: “It was certainly a baptism by fire from that aspect.”<sup>129</sup>

## The Elliot Lake Fire Department also fails to hold a debriefing session

Chief Officer testified it was the Fire Department’s practice to hold a debriefing after a large event, but one was not held after these rescue efforts ended. When the incident ended on June 27, 2012, half of his team left for holidays. People needed to rest. As fire chief, he actually took advantage of the mutual aid system to have other departments cover his fire hall for that weekend.<sup>130</sup>

Even after a rest period, no debriefing was held or even attempted. Chief Officer agreed debriefing was a useful tool for bringing information to the table – spotting what could be done better and what was done well, and trying to make improvements. Despite these benefits, he did not hold the debriefing because, for emotional reasons, his firefighters did not want to open up to the experience again:

I was a little concerned bringing it forward and there didn’t – typically, the guys have absolutely no issue doing these ... [after-action reports], but in this particular case, there seemed to be very little interest in doing it and I think that the fire fighters didn’t want to open up to the experience again.

Q. For emotional reasons?

A. Yes.<sup>131</sup>

## Suggestions for improvement from the Elliot Lake Fire Department

Chief Officer was asked during testimony whether he saw areas for improvement. His initial answer was that he could not think of any because everyone at the scene was working toward the same goal, without friction:

[T]here was no bickering, there was no fighting on the scene. Everybody that showed up on that scene tried to drive the event to move it forward ... in the direction that we needed to go, and that is the rescue.”<sup>132</sup>

Chief Officer did, however, suggest that communications with the media, community, and families could have been improved. With hindsight, he said, he would have “been much more forceful” in getting in front of a camera to convey that there was one casualty, but another individual they hoped to recover. He felt that more openness about these issues would have helped. He could relate to the families’ and the community’s feelings of helplessness, having at times felt helpless during the operation.<sup>133</sup>

Chief Officer also suggested that UCRT’s role was perhaps not acknowledged to the extent it should have been. He actually took the time shortly after the event to issue a press release that, among other things, thanked the UCRT team for its efforts. He felt they were a little “overshadowed” and wished to thank the members for their work.<sup>134</sup>

Chief Officer also felt that some of his firefighters deserved recognition for their bravery. Since the Algo Mall response, he has taken the time to nominate nine firefighters who spent the majority of their time on the pile at the start of the emergency response for the Ontario Medal for Firefighter Bravery Award, given by the Ontario Honours and Awards Secretariat. That application is on hold until this Inquiry is completed.<sup>135</sup>

Chief Officer also saw room for improvement in the area of note-taking. He intended to make a recommendation to the Ontario Association of Fire Chiefs that more training be provided for scribes. Following the deployment he noticed that, on occasion, what was written down by his scribe was not 100 percent accurate. He saw a tendency



to write down what the scribe thought was happening. He also wished there could have been more information in the notes.<sup>136</sup> As well, he felt that he should have allocated a scribe to the officers who covered for him as incident commanders when he was not on the scene.<sup>137</sup>

When Capt. John Thomas of the Elliot Lake Fire Department testified, he told the Commission that he saw many positives but also saw room for improvement in the areas of communication with the public and media relations. In terms of positives, he felt the Elliot Lake Fire Department's relationship with HUSAR/TF3 was excellent. He did not personally experience any communication problems or personality conflicts. The relationship with UCRT was equally good. UCRT did not attempt to usurp the Fire Department's incident command, sought input, and behaved in a professional manner. He did not see friction between UCRT and HUSAR/TF3, nor did he see bad judgment calls or bad advice from either entity.<sup>138</sup>

Capt. Thomas, like Chief Officer, did feel, however, that communications with the public were not handled well. The media did not provide accurate information. Citizens should have been given updates, including the fact that the rescuers were inside the building on the rubble pile. He was particularly troubled by the misconception that existed during the rescue about the number of potential victims being as high as 31. He described those figures as "out of whack." He himself, from the beginning, never thought the number was more than three or four bodies in the collapse zone.<sup>139</sup>

## **The Office of the Fire Marshal creates an after-action report with suggestions for substantial change to Ontario's search and rescue model**

Officials from the Office of the Fire Marshal (OFM) who were present at the Elliot Lake scene held a final meeting before leaving. It was a brief and informal discussion, short of a proper debriefing session, and amounted to a non-systematic canvassing of views about what went right and wrong. No formal debriefing session was ever held. One was scheduled, cancelled, and never rescheduled.<sup>140</sup>

The OFM nevertheless produced an after-action report dated November 14, 2012.<sup>141</sup> The report made substantial suggestions for improvement related to quicker response throughout Ontario for structural collapses, clarification of roles and responsibilities in relation to HUSAR/TF3, mandatory imposition of the Incident Management System (IMS) throughout Ontario, and improvements to leadership capabilities during large-scale emergency response situations.

In terms of improving response times in Ontario, the OFM after-action report noted that HUSAR/TF3 was originally created in response to potential terrorist attacks in chiefly urban settings. Since its inception, however, the team has been deployed exclusively for domestic, non-terrorist emergencies in smaller centres such as Elliot Lake, Woodstock, Goderich, and Windsor and in areas quite a distance from Toronto. The OFM therefore suggests the creation of light and medium urban search and rescue teams spread throughout the province for "early reconnaissance and on-ground expertise in advance of the arrival of advanced USAR capabilities." The following passages capture the OFM's suggestions:

[T]he USAR response model in Ontario should be re-evaluated to effectively and efficiently serve the entire province.

Consideration should be given to establishing a first-response USAR capability at the "light" and "medium" levels amongst fire services across Ontario. This would provide for early reconnaissance and on-ground expertise in advance of the arrival of advanced USAR capabilities. This could be accomplished

through similar arrangements as exist for the six Level 2 teams that support the Level 3 CBRNE / Hazmat teams across the province.

Given the withdrawal of federal funding for HUSAR teams (Toronto), it may be timely to re-examine Ontario's response needs for structural collapse expertise and resources. Consideration should be given to geographic distances (i.e. response times), the ability to provide lighter, faster teams for early assessment and stabilization of collapse scenes on a geographically distributed basis. Historically, particularly since 9/11, focus has been on urban centres (i.e. Toronto) with infrastructure that is potentially a target of terrorist activity. We now know through experiences such as: Elliot Lake, Woodstock, Goderich, and Windsor that the same capabilities are critical as applied to unintentional/accidental collapses. OPP UCRT has light-medium USAR capabilities, but from one location in southern Ontario. Reconfiguration of fire service-based capabilities and redistribution of funding to establish, for example, three medium teams (MUSAR) equipped and trained to this recognized level of response, would allow for a complement to OPP UCRT as well as faster reach within the province.<sup>142</sup>

The OFM after-action report also saw room for improvement in the areas of HUSAR/TF3 training and clarification of roles and responsibilities. The current HUSAR/TF3 memorandum of understanding places the responsibility for training on the OFM and Emergency Management Ontario (EMO) in one instance, but on the OFM and the City of Toronto in another. This situation is then complicated by the fact that, in the field, the Provincial Emergency Operations Centre (PEOC, a non-participant in training) coordinates the activities of HUSAR/TF3 and other agencies. The report also notes that the MOU does not address whether HUSAR/TF3 should be coordinated by the OFM or EMO, while the City of Toronto has historically taken the position that the team is coordinated by neither of these entities but, instead, by the HUSAR/TF3 team leader. The OFM suggests that this practice is inconsistent with current IMS protocol, which dictates that the local jurisdiction retains command and control. Given this confusion about training and coordination, the OFM suggests that the MOU and the HUSAR operating manual be revised to "clearly distinguish the respective roles and responsibilities of the OFM, EMO and the City of Toronto HUSAR Team in relation to complex emergencies" and the streamlining of the governance model for the HUSAR / CBRNE teams.<sup>143</sup>

The OFM after-action report also noted that, pursuant to section 9.2(a) of the *Fire Protection and Prevention Act, 1997*, it is the fire marshal's duty to investigate "the cause, origin and circumstances of any fire or of any explosion." The OFM suggests that, as this investigation often involves working closely with demolition experts and dealing with failed structural elements, consideration should be given to having the OFM be the lead response for all building collapses and that the OFM response model be augmented as follows:

The response model (team) be augmented by other OFM staff with emergency response command experience, a communications expert (from within OFM or ministry), and a representative from EMO to facilitate communication between emergency responders during response / recovery phases and the EOC (consequence management) and within government via the PEOC.<sup>144</sup>

The OFM report also made recommendations relating to IMS and leadership assistance during major incidents. These include the following:

- Mandatory adoption of the Incident Management System for all provincial agencies, including municipal emergency response agencies and other agencies with the potential for involvement in a major emergency: "All agencies should be able to demonstrate adoption of IMS through the attainment of training specified by the province" (i.e., provide training records).
- Development of criteria to determine the circumstances under which senior government officials attend an emergency operations scene and the impact of their presence on the broader IMS hierarchy (i.e., clearly define the role of those officials within that hierarchy).

- Development of a team (or teams) of experienced fire service command officers from within the mutual aid systems to support local jurisdictions during prolonged incidents and to provide direct guidance and support when the expertise of the local jurisdiction is limited. (The OFM proposed a model resembling the one used by police services in similar circumstances.)<sup>145</sup>

With respect to the IMS, the OFM noted that incident command was used by Chief Officer during the Elliot Lake deployment, but that not all parties fully adhered to the system. No one particular agency existed to ensure the system was successfully implemented. In the absence of a designated lead, the HUSAR/TF3 team leader took on a number of roles “including that of overall incident commander, and communications spokesperson.” As proof, the OFM pointed to the “fact that the Premier and the Commissioner of Community Safety communicated directly with the HUSAR team leader.” If the Incident Management System had been used properly, the HUSAR/TF3 lead (Staff Insp. Needles) would have been a “sector chief reporting to the Incident Commander who would have been the fire chief for emergency response purposes.” The fire chief would then have been responsible for communicating with the Provincial Emergency Operations Centre. This incomplete implementation of the IMS was viewed in the after-action report as having “detracted from effective coordination, communications, and decision making between emergency responders, the EOC, and provincial agencies.”<sup>146</sup>

**This incomplete implementation of IMS was viewed in the after-action report as having “detracted from effective coordination, communications, and decision making between emergency responders, the EOC, and provincial agencies.”**

The report also noted that, while the deployment of the commissioner for community safety (Dan Hefkey) to the scene was generally positive, his presence created even more confusion about roles and responsibilities of the City of Elliot Lake and the provincial government.<sup>147</sup>

The OFM reiterated the importance of adopting an IMS throughout the province:

It is important to note that the current IMS doctrine has not been formally adopted by all agencies and responders in Ontario. Participation is voluntary and not required by legislation; therefore its overall effectiveness in a multi-jurisdictional response is limited.<sup>148</sup>

## Suggestions for improving victim services

### Algoma Victim Services

Algoma Victim Services held a debriefing for staff and volunteers on July 18, 2012.<sup>149</sup> Robin Kerr, the executive director of Victim Services of Algoma, explained, though, that this event was a “critical incident stress debriefing.” A counsellor and two other individuals were brought in. It was not an operational debriefing, but an “emotional debriefing so that we can move on, hopefully, from the four days that we were here at the Collins Hall.” No operational debriefing ever occurred.<sup>150</sup>

During testimony, Ms. Kerr made some suggestions for improvement in the area of victim services. She suggested first that the families of victims need to be kept separate from the general public and be provided with the assistance of more dedicated individuals. Her staff changed constantly. The families of the victims in Elliot Lake did not have a constant, dedicated presence and the necessary privacy.<sup>151</sup> While there was a place at the Collins Hall to speak to the families in private, it was not very big. It could fit only two or three people at a



time. For the most part, the families occupied the same space as the general public, which did not play out well, especially when the announcement was made that the rescue would be stopped. Ms. Kerr described the chaos at that point in time:

Again, the anger, the disbelief, the shock. So by having the general public and the families all in one room, they fed off of each other. So if the general public became distraught, which might have been – the families maybe could have dealt with the information differently had they been given that opportunity to do it privately, but here was horrible news being given to them in front of the public. They weren't given that opportunity to digest this information privately and to work with the police or whomever there.

So the anger that maybe came from the community fuelled through everybody, and the whole hall became angry and distraught, and it really was chaos. We were doing our best to put out as many fires, for lack of a better term, that we could to hold people together.<sup>152</sup>

Ms. Kerr also suggested that it would have been beneficial to have the involvement of OPP victim liaison officers at an earlier point in time.<sup>153</sup> When the OPP made the decision to send victim liaison officers to assist the families on June 26, things improved substantially for the families. They no longer needed to be at the Collins Hall, and Ms. Kerr understood that, by all accounts, these officers took good care of the families.<sup>154</sup>

Ms. Kerr also agreed that emergency response plans should contain provisions relating specifically to caring for family members of victims or possible victims.<sup>155</sup>

Finally, Ms. Kerr saw room for improvement in creating a plan for the set-up of the Collins Hall. She felt it took time to get the hall properly organized and to bring in food and similar items. Although the City did provide food and a staff member, Ms. Kerr said it was, in fact, the community as a whole that came together to organize the hall.<sup>156</sup>

## The families see room for improvement

**“We should have had updates on an hourly basis, not every eight, ten hours or at least tell us the truth, you know what I mean? If you don't think it's going well, tell us, and if it's going well, tell us.”**

**– Darrin Latulippe**

Darrin Latulippe, Doloris Perizzolo's son-in-law, felt that he and his wife, Teresa, were treated well in some respects during the rescue efforts but not in other respects. He was happy that they were provided somewhere to go during the rescue (presumably a reference to the Collins Hall). This arrangement allowed, for example, for a bond to be created between the two families.<sup>157</sup>

Mr. Latulippe was critical of the Red Cross and Algoma Victim Services. He felt those organizations should have provided more support at the critical point in time when Staff Insp. Neadles announced that the rescue would be called off. Mr. Latulippe's impression was that these agencies, at this critical time, were on their Blackberries, as opposed to stepping up to provide victim services.<sup>158</sup>

He felt, as well, that the families should have received hourly updates, as opposed to every eight to 10 hours. He candidly stated that the families wanted the truth on the progress of the rescue:

We should have had updates on an hourly basis, not every eight, ten hours or at least tell us the truth, you know what I mean? If you don't think it's going well, tell us, and if it's going well, tell us.

Don't just say yeah, we're making progress, we're doing this, we're doing that. That's not what we want to hear. We want concrete answers, are you going to get them? What are you doing? How close are you? ... That's what we wanted to know and nobody would tell us. We got most of our information off the radio.<sup>159</sup>

Réjean Aylwin, the father of Lucie Aylwin, was also critical of the way updates were provided on the state of the rescue. His view was that information was provided to the media before the families received it.<sup>160</sup>

Mr. Latulippe was also critical of the way in which the bad news about the rescue being stopped was communicated to the two families. This communication was done by Staff Insp. Neadles, Insp. Jollymore, and Mayor Hamilton and, therefore, was less within the control of Victim Services. Mr. Latulippe nevertheless felt this aspect was not handled well. His wife was told the news when sitting by herself in a public space. The family was not given a chance to get together. He was particularly critical of the fact that the news of the rescue stoppage was communicated in a public place. It should have been done in a private space, with all the family present. Providing the news in public at the Collins Hall was “like telling somebody that your family died in a car accident while you are sitting at a hockey game.”<sup>161</sup>

Gary Gendron, Lucie Aylwin’s fiancé, thought that, as a family member of a victim, he was lucky that institutions such as Canadian Tire and No Frills provided air mattresses, sleeping bags, water, and fruit. He spoke of some small bit of help from police officers and counsellors, including the Red Cross, but thought there should have been more involvement from the City: “It was pretty much just friends, family and the community that held us up.” He testified that the Member of Parliament and Member of the Legislative Assembly were of assistance, but not the City councillors.<sup>162</sup>

Like Mr. Latulippe, Mr. Gendron also felt the families needed more regular updates, provided first to the families:

No, they were telling us they’d give us an update every two to four hours. That wasn’t true. We would get – sometimes it would take six hours before we’d get information, and then they would go to the media before they’d come to the family. That’s wrong ... I think the families should know more information before the media should know the information.<sup>163</sup>

Mr. Gendron even went so far as to suggest that the families should have had radio/CB access to allow them to follow what was going on inside the building, at least to some extent. He also felt the families of the two victims, once identified, should have been restricted to a different area from the public, as became the case on Monday and Tuesday when they were sent to a separate location. Before that, the victims’ families were located with the rest of the public at the Collins Hall.<sup>164</sup>

The point of view of these family members stands to be contrasted with Insp. Jollymore’s impression of how the victims’ families were treated. He felt the OPP did a good job in keeping the families of the victims informed of what was going on during the rescue. He told the Commission he made sure that his counterpart on the nightshift went to the Collins Hall every two hours to provide an update and reassure the families that they were being given updated information “as best we knew it.” He said he also arranged for the Critical Trauma Support Team to assist even though this role was usually beyond their scope of duties. Eventually, a “public liaison team” was assigned directly to the families (presumably a reference to the OPP’s victim liaison officers): “It really helped once we identified the two families because it allowed us to narrow our focus and supply resources directly to them.”<sup>165</sup> He gave the following summary of his involvement in assisting the families:

So about 35 times – there is 35 issues where I either went to the families, or I was looking after the families or making notations about how the families were being looked after between Saturday ... when the mall collapsed and Monday evening.<sup>166</sup>

“We would get – sometimes it would take six hours before we’d get information, and then they would go to the media before they’d come to the family. That’s wrong ... I think the families should know more information before the media should know the information.”  
– Gary Gendron

## The Millennium crane's owner and operator provides suggestions for improvement and criticizes perceived limits in HUSAR/TF3's skill set

Dave Selvers, the owner of Millennium Crane as well as the crane's operator, created a report about his involvement with the Elliot Lake deployment, despite being a civilian actor at the scene. Mr. Selvers was critical at times of different individuals and agencies, and he made suggestions for improvements in the future.<sup>167</sup> He was also critical of many aspects of the rescue operation. The observations, criticisms, and suggestions for improvement that he made related to a wide range of topics – including, but not limited to, crane operations.\* He focused to a large degree on what he perceived as gaps in the HUSAR/TF3 skill set, particularly in the areas of rigging and steel shoring.

First, Mr. Selvers said that he received incorrect information when initially informed about the operating radius (distance from the exterior of the Mall to the collapse site). If he had had the correct information, he would have contacted the 165-tonne crane operator sooner, because the individual had a long distance to travel to the site.<sup>168</sup> He suggested that, in the future, it would be useful to have a picture or video in order to better understand the layout of the site.<sup>169</sup>

Mr. Selvers was also critical of the time it took to request the services of Millennium Crane. He noted that the first call he received was at 11:15 p.m. on June 23, almost nine hours after the collapse.<sup>170</sup> In testimony, Mr. Selvers explained that, if he had been called around the time of the collapse, he might have made it to the site from Sault Ste. Marie by 9 or 10 p.m. that evening (he arrived in Elliot Lake at 11:15 the next morning). He could then have been hoisting by midnight or 1 a.m. He would have been mobilizing in daylight hours, without the adverse weather that developed later that night.<sup>171</sup> He stressed the importance of having the right heavy equipment on site, including cranes and a suspended work platform, and quickly dispatching that equipment:

It is imperative that heavy equipment manned with experienced operators be properly deployed in any state of emergency. Vital equipment includes Cranes of adequate capacity capable of hoisting debris as well as multiple personnel (suspended work platform). A suspended work platform will permit an aerial means of access into a hole or recessed / collapsed area. We want to minimize exposure to shredded and hanging debris so as to prevent un-necessary injury to rescue workers.

Earth moving equipment i.e. Dozer(s), Excavator(s), Pay-loaders and Boom attached Shears are additionally crucial.

Cranes and Earth Moving equipment are vital components in any rescue operation. And must be immediately dispatched.

Mr. Selvers directed some harsh criticism toward HUSAR/TF3 based on his impression that its presence was redundant. He felt that all that was required for this operation was the large crane, the OPP, and the ironworkers – or, as he put it: "O.P.P. in the hole, Iron Workers unhooking on the outside ... ALL ELSE WAS REDUNDANT AND NON-PRODUCTIVE." He said the following about the Toronto HUSAR/TF3 team:

With no intentions of malice or bias and with all due respect to H.U.S.A.R. personnel I do not see any purposeful function other than to amass a budget (political waste). They were of no use whatsoever in a situation such as this. The fact that they didn't even call for cranes is proof of their incapability. How did they think they were going to lift the debris off any survivors? How did they assume their approach into

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\* It should be noted that not all of Mr. Selvers's criticisms are included, only those that I perceived as worthy of mention and flowing from Mr. Selvers's particular expertise and experience.



the hole without using a suspended aerial approach? This team did not have any idea as to the means required to perform this operation. Again this is a personal “seasoned” observation with no malicious intent toward anybody’s ability or character.

...

The only productive effort was that of the Ontario Provincial Police and Millennium Crane crew. All else was redundant and ineffectual. There was no evidence that the H.U.S.A.R. team was capable or even suitable for this type of operation. Being questioned as to why we had brought a suspended work system was proof that there was no skilled people on site.

...

... [A]ll the individuals involved in the Heavy Urban Search and Rescue Team displayed limited efficiency. Was this the result of a poorly organized game plan? Was it due to poor communication? Was it because of a lack of leadership or an inattentive rescue team?<sup>172</sup>

Mr. Selvers was also critical of the command structure (or the lack thereof). He was unsure who was in charge at the scene. He noted, for example, that more than once and by different people, he was told to pack up and leave the scene:

Protocol ... who is in charge? Only the party/individual responsible for making call to contractors is authorized to release the same entities. Throughout this operation many different person’s [sic] were giving orders resulting in poor communications (potential for further complications). The Ontario Provincial Police were exceptional in there [sic] communication and overall were competent in their work and given the fact that Millennium was working directly with the O.P.P. there was no confusion and efficient communication.

...

A major problem evident on this site was the fact that too many people were relaying too many different messages.

In a situation such as this or in any disaster situation it is vitally important that ONE person be the Designated Planner. From this point, if required, there will be designated messengers assigned to relay information to each work group involved in the rescue operation. Each work group messenger will also be responsible for the gathering of information and status reports relayed back to Designated Planner ... all of whom will maintain audio / visual contact with each other.<sup>173</sup>

In his testimony, Mr. Selvers reiterated his concerns about the command structure. He told the Commission that, during the operation, he went into the HUSAR/TF3 tent on a few occasions and noticed information being exchanged with no real solutions being offered. He saw a lot of people not doing anything and looking for direction. He did not see a designated planner on site. He became frustrated because he never knew “what directive was going to be fired at me next” and by the fact that everybody was “congregated and huddled” in the command tent. Nobody came to him for a progress report or to ask him about next steps.<sup>174</sup> Mr. Selvers agreed that a possible solution might be joint training between crane operations such as his and the UCRT and HUSAR/TF3 teams.<sup>175</sup>

During his testimony, Mr. Selvers was critical of the fact that HUSAR/TF3 used only wood shoring during its operations. He felt that his team was actually better equipped. Indeed, he explained that this fact was the impetus for the conclusion in his report that HUSAR/TF3 was of no use when he first arrived on scene:

[I]t was beyond me as to why they were using wood to shore up concrete and steel when we had arrived with HSS beams, you know, a thick gauge angled material, cable lashing up to five-eighths and half-inch turf. We had everything we needed to shore up this structure, even to add to the structure, and nobody wanted to consider it.

And when I saw people trying to approach the rubble from inside the building, and obviously they were trying to shore something up, but wood isn't going to do it. If the building were to torque in one way or another and twist, that wood is not going to hold up to it. You know, they were framing; they had wooden posts. And wood does have a good structural strength to it, but it doesn't have the tensile elasticity because of its brittleness that steel would.

So it wasn't going to compensate for any torsional dynamic loading in the – in the structure itself. That would only be – you can only accommodate that with a steel structure or guide wires. That is where the lashing would have come into play.

But when I saw that nobody wanted to use, implement professional ironworkers, I knew that I was working with people who weren't well versed in this industry.<sup>176</sup>

It was suggested to him that HUSAR/TF3 uses wood shoring because it provides an early warning sign if the structure is about to collapse – one can hear it cracking and bending.\* He disagreed, saying the collapse would follow immediately on any cracking sound:

[Y]ou would hear the crack, and it would come down. It would be immediate. Once you hear that crack, it would be immediate ... There is no tensile elasticity with wood. It just snaps.<sup>177</sup>

Staff Insp. Neadles was referred to Mr. Selvers's comments. With respect to HUSAR/TF3's use of wood for shoring, he said HUSAR/TF3 never used steel shoring. He knew that engineer James Cranford and Capt. Comella discussed the use of steel shoring, but he thought it was merely a discussion. He seemed to think that HUSAR/TF3 lacked the ability to work with steel shoring, perhaps confirming Mr. Selvers's impressions at the scene:

Q. Okay. So it [steel shoring] was an avenue being explored, or was it just being talked about for its own sake?

A. As far as I know, it was just being talked about.

Q. So it would be pretty much of a waste of time between the two of them?

A. Well, ... we would have to ask how they are going to do that, because *obviously we don't have any experience with steel. None of our rescue teams have experience with steel.*

Q. Okay, so there would be nobody on the TF-3 team that would be trained to construct steel shores?

A. Not to my knowledge, no. It is not in our training at all.<sup>178</sup> [Emphasis added.]

Staff Insp. Neadles also agreed with Mr. Selvers's comments about HUSAR/TF3's lack of expertise with rigging: "[I]t's something that we aren't expert in because that is not part of our NFPA [the US National Fire Protection Association] standard, so we have not undertaken a rigging ability."<sup>179</sup>

Staff Insp. Neadles was also asked about Mr. Selvers's comments on the lack of organization and leadership. He said that he did not even recognize Mr. Selvers as someone he saw in Elliot Lake. I find this response surprising and somewhat confirmatory of Mr. Selvers's evidence that HUSAR/TF3 command was not highly attuned to the rigging work that was undertaken. Staff Insp. Neadles did agree with Mr. Selvers's suggestion that it was vitally important that one person be designated as planner, and that such a person was missing from this deployment.<sup>180</sup>

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\* This suggestion was put forth as the justification for use of wood shoring by Capt. Comella during his testimony: Comella testimony, September 5, 2013, pp. 24114, 24238–9. At pp. 24238–9, Sgt. Comella states: "Steel is not a preferred material for a rescuer; it is for construction but we use wood as an early warning system. So if we had a choice we would rather build a more robust wooden structure that would give us early warning of movement and continued movement than we would to have a steel structure that would give us basically no warning and a catastrophic failure which is our understanding of a steel failure."

Otherwise, Staff Insp. Neadles took issue with many of Mr. Selvers's criticisms. While Mr. Selvers may have perceived that people on the ground were standing around, Staff Insp. Neadles told the Commission that HUSAR/TF3 members could just as well have been awaiting new orders. He felt that Mr. Selvers had no business going into the command tent and probably had no permission to venture into prohibited zones to do his own assessments. Not being an engineer, he was not really in a position to assess the stability of the structure. Staff Insp. Neadles also objected to Mr. Selvers's criticism of HUSAR/TF3 for not having ordered a crane – HUSAR/TF3 knew that the OPP had already done so.<sup>181</sup>

## Ministry of Community Safety and Correctional Services

### The Ministry of Community Safety and Correctional Services' After-Action Report

The Ministry of Community Safety and Correctional Services (MCSCS) produced its Elliot Lake Consolidated After-Action Report. The final version of this report is dated September 27, 2013, more than a year following the events in question and the calling of this Inquiry.<sup>182</sup> Mr. Hefkey, the commissioner for community safety, was asked why it took so long to produce the report. He explained that it was a consolidated report that required input from individual divisions. The ministry had also failed to produce the document in its draft form to the Commission despite a request to do so and provided no satisfactory explanation for the late disclosure of the contents of this report.<sup>183</sup>

The report indicates that an Oversight Committee was established to consolidate lessons learned from areas of the ministry involved with providing resources to support the municipal response to the Mall collapse. Five after-action reviews – from five areas of the ministry (the commissioner for community safety, the Corporate Communications Branch, Emergency Management Ontario, the OPP, and the Office of the Fire Marshal) – were used to create the consolidated report.\*

The focus of the MCSCS after-action report was on the "opportunities for improvement in supporting a municipality's response to future incidents and is not intended to detract from the positive elements of the response to the Elliot Lake mall collapse." The positive aspects of the response, according to this consolidated report, included:

1. The timely authorization and mobilization of HUSAR and other rescue assistance sent to the collapse; and
2. Support by the OFM and EMO to community officials as they managed the incident and its effects.<sup>184</sup>

The ministry saw opportunities for improvement in three areas: roles and responsibilities, deployment and coordination of provincial resources, and public communications and internal information-sharing. The ministry stated that its intention in the consolidated report was to establish a multi-jurisdictional committee to act on the recommendations set out in it and to review and consider the findings and recommendations of this Commission.<sup>185</sup>

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\* Exhibit 9912, p. 002. The OFM and OPP reports have been summarized. Repetition of the points made in those reports will be avoided, if possible.



The summary of the after-action report that follows should be read with care because I am concerned that it may have been based on incomplete details about the rescue and recovery operation. For example, when he gave evidence, Mr. Hefkey, one of its authors, appeared not to know that there were delays related to the ordering of the Millennium crane, that the Millennium crane was actually able to lift the slabs that had fallen on Lucie Aylwin, and that the rescuers had come to within only two slabs of reaching her. I discuss Mr. Hefkey's perception of the facts below.

### **Perceived deficiencies and recommendations related to roles, responsibilities, and use of the Incident Management System**

The report stated that during the deployment there was insufficient understanding of the roles and responsibilities of the provincial and municipal responders, and that the IMS was not being applied consistently. Despite this statement, the report asserted that deficiencies related to roles and responsibilities and the application of the IMS did not create any delay or hamper rescue efforts:

To be clear, any deficiencies in clarity and coordination of roles and responsibilities or any failure to strictly adhere to policies and procedures did not result in a delay in response time or encumber the efforts of the rescuers to the mall collapse. Still, the following deficiencies may have caused some confusion among some responders during the response.\*

After repeating some of the concerns raised by the Office of the Fire Marshal relating to HUSAR/TF3 activation and training and the role of the OFM in investigating structural collapse, the MCSCS after-action report saw specific deficiencies related to the Elliot Lake deployment in the following areas:

- “The effectiveness of IMS was not maximized because no single person was understood to be incident lead by all responders.” This situation “may have detracted from effective coordination, communications, and decision-making.”
- “The role of political representatives and/or senior bureaucrats arriving on the scene was not clearly understood and added to the complexity of the incident.” It was seen as a positive action that the commissioner for community safety attended on scene, but his direct contact with HUSAR/TF3 late on June 25, 2012, created confusion among some responders as to roles and responsibilities.
- There was a public perception that the Ministry of Labour ordered the rescue stoppage, when in fact an MOL engineer was merely assisting in providing expert advice alongside the HUSAR/TF3 engineer.
- There was confusion about jurisdiction over the collapse site at the conclusion of the rescue operation. It was unclear if the MOL, the Office of the Chief Coroner, the local municipality, or the OPP had “predominance of purpose.” Because of the uncertainty, “there was concern expressed by some responders that the site might be turned over to the owner to deal with removal of the deceased along with the demolition of the building.”<sup>186</sup>

The consolidated after-action report therefore made the following recommendations:

- “Validate” the continued use and adoption of the IMS in Ontario emergency response and incident management and, following consultation, “determine opportunities to evolve and/or further the adoption and continued application of the IMS in Ontario.” (This recommendation is unlike the Office of the Fire Marshal’s recommendation for mandatory adoption of the IMS.)

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\* Exhibit 9912, p. 008. Again, it must be borne in mind that the MCSCS and the authors of the report appear to have had no knowledge of the delays in ordering the Millennium crane on the first day of the rescue and of the importance of that crane to the rescue efforts.

- Enhance Ontario's ability to support the municipal response to building and structural collapse events by developing a new building and structural collapse response model. (The report gave the example of deployment of urban search and rescue teams of different levels – echoing, it seems, the recommendations made by the OFM.)
- Create an “interoperable telecommunications capability” by seeking additional bandwidth for public safety purposes, presumably so that all responders can be on the same band-width during a response.
- Provide guidance to local first responders to ensure that an appropriate command structure is established at the initial stages of a response, and to ensure mutual understanding of the command structure when local first responders and provincial teams interact.
- Clarify definitions of terms such as “emergency response,” “emergency management,” “IMS,” “unified command,” “unity of command,” and “incident command” to ensure these definitions are reflected in all plans.
- Review emergency response plans to clarify the province's role during an incident that is not a provincially declared emergency.
- Consider the creation of municipally, regionally, and/or provincially based incident support teams, staffed with personnel with experience in the management of complex incidents. Such teams would supplement local resources where an emergency overwhelms a local municipality's ability to respond to an incident.<sup>187</sup>

In terms of deployment and coordination of provincial resources, the report stressed the importance of ensuring that the right people and resources arrive at the scene in the most expeditious way possible. The report stated that the decision-making process to deploy HUSAR/TF3 and UCRT was “rapid and effective” and accomplished in a timely manner, considering the geographic distances involved. However, the ministry saw room for improvement in terms of coordination of command between the two teams and noted that a question had arisen about whether there should have been a separate commander for each of the HUSAR/TF3 and UCRT teams or whether there should have been a single commander for the two combined.<sup>188</sup>

The report therefore recommended ways of improving the working relationship between the two entities, including the creation of additional opportunities for joint training and interaction between UCRT and HUSAR/TF3. These initiatives would focus on the relationship between urban search and rescue and the incident management structure that would be in place when both teams deploy together.<sup>189</sup>

The report also noted that there was an absence of a single lead to coordinate all the liaison supports for the provincial entities on the ground. People had been deployed from the OPP, the OFM, Emergency Management Ontario, the MOL, the MCSCS Communications Branch, the Office of the Chief Coroner, and the Office of the Premier. The report suggested there was also a lack of understanding of the roles and responsibilities of these entities. It therefore recommended:

- early engagement of an EMO field officer with the municipal officials and deployment as necessary;\*
- review of existing arrangements that assist in identifying provincially based personnel and equipment available for deployment; and
- engagement with the MOL to distinguish between the legislated role of MOL engineers and inspectors and the “possible provision of advice and assistance in support of deployed urban search and rescue resources at the scene of an incident.”<sup>190</sup>

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\* Former Ontario premier Dalton McGuinty specifically raised the faster deployment of an EMO official to the scene as an area for potential improvement: McGuinty testimony, October 9, 2013, p. 28971.

## Perceived deficiencies and recommendations related to public communications and internal information-sharing

The MCSCS report referred to internal and external shortcomings in provincial communications. The document suggested that the Elliot Lake incident revealed a need for a “coordinated municipal-provincial approach to public communications.” This approach would allow the practitioners to focus on the response operation, while ensuring better communication with respect to the emotional climate, the political situation, and the rationale for decisions.<sup>191</sup>

The document suggested that the Elliot Lake incident revealed a need for a “coordinated municipal-provincial approach to public communications.”

The report noted that communications worked well in Elliot Lake once it was decided to have a provincial spokesperson on site to provide media outreach, but this practice did not begin until June 26. Before that, several problems were noted, including:

- the absence early in the incident of a single person to coordinate media relations on the province’s behalf;
- limited communications support for local officials and responders. For example, the HUSAR/TF3 lead participated in multiple media requests and town hall sessions at a time when significant operational demands also existed;
- early media reports based on inaccurate information because journalists and the public were not receiving timely and accurate information;
- a lack of coordination among provincial communications staff from MCSCS, Cabinet Office, and the Office of the Premier;
- fluctuating numbers of persons reported missing “leading to public speculation and increased anxiety, which should be noted is a reoccurring problem in these types of situations”; and
- a lack of a robust and effective strategy to handle social media and mitigate public speculation and concerns.<sup>192</sup>

In terms of areas for improvement, suggestions in the report included:

- immediate establishment of a coordinated approach to internal and external communications;
- review and revision by the MCSCS’s Communications Branch of its provincial communications strategy to take into account both municipal and provincial protocols and interests;
- immediate identification of a provincial communications lead and protocol for critical incidents;
- increased capacity to provide communications via social media; and
- revision of the HUSAR/TF3 memorandum of understanding with the City of Toronto to clarify communications roles when HUSAR/TF3 is deployed.<sup>193</sup>

## Commissioner for community safety’s commentary on the MCSCS after-action report and areas for improvement

Mr. Hefkey was questioned on both the consolidated after-action report and his opinion on areas for potential improvement in emergency response flowing from the Elliot Lake deployment.



### **Mr. Hefkey acknowledges that the MCSCS report did not question HUSAR/TF3 deployment speed**

Mr. Hefkey was questioned about the fact that the after-action report produced by his ministry did not take issue with the speed of HUSAR/TF3's deployment. The team did not leave Toronto until 9:35 p.m., seven-and-a-quarter hours after the collapse and about six hours after the formal request. When pressed on whether this was the best that could be done, Mr. Hefkey said: "You always strive to do better." However, he pointed to the HUSAR/TF3 MOU, which called for the team to be up and running in a six-hour window, implicitly suggesting that the HUSAR/TF3 deployment speed was acceptable.<sup>194</sup>

Interestingly, Mr. Hefkey suggested that a source of delay for HUSAR/TF3 may have been the fact that members were either off-duty or needed to first find replacements before they could deploy. Although he agreed lives were at stake and there was a need for rapid deployment, he said there was an understanding with the City of Toronto with respect to the need to find replacements and to ensure that, before HUSAR/TF3 helps outside Toronto, Toronto itself is not left vulnerable:

[T]he understanding that we have with the City of Toronto is that those resources, those specialized resources, ... could be sitting in the Fire Hall, but that that person could potentially be a member of that particular team that will go to a fire, and they go as a team to those fires. And so what you don't want to do is create risk and create a vulnerability within your own municipality in order to go to another municipality to address the emergency that is there.

...

Again, the understanding that we have with the City of Toronto is that they are committed and have invested significant resources and time and money to creating this Heavy Urban Search and Rescue team, and that that team, in order for that team now to deploy outside of its jurisdiction, the City itself is saying, "We don't want to create a vulnerability to our community as a result of saying, 'Yeah. We'll help with the provincial capability.'"<sup>195</sup>

It seems clear to me that an important factor in defining a deployment time frame of six hours is a considered accommodation to Toronto's concern about its potential vulnerability, in preference to the need to prioritize a distant immediate emergency. The actual time required to assemble equipment and personnel is not the principal criterion. It was pointed out to Mr. Hefkey that the evidence indicated that getting the kit together took only about an hour, and he was again pressed on why it was acceptable for HUSAR/TF3's departure to be delayed to accommodate the hypothetical needs of the City of Toronto. He seemed reluctant to agree that Toronto's needs took precedence, to a degree, over the provincial need for HUSAR/TF3 deployment and said the provincial government is currently looking at whether the province's urban search and rescue capabilities need to be structured differently in order to allow for more rapid deployment to areas outside Toronto.<sup>196</sup>

Although his answer on this point was not entirely clear, Mr. Hefkey appears to have given direction to the Office of the Fire Marshal and Emergency Management Ontario to study whether the province needs more medium-sized urban search and rescue teams, as opposed to – or in addition to – the heavy team.<sup>197</sup>

### **Mr. Hefkey's testimony shows he did not know what the Millennium crane was used for and that delays in ordering it affected the rescue**

Mr. Hefkey was taken through the evidence about ordering the crane, including Cst. Cox's evidence that Insp. Jollymore waited to order the crane until 11:15 p.m. on the Saturday, despite the need having been recognized at 5:30 p.m. The crane, in turn, did not arrive until 11:15 a.m. the next day. His attention was also drawn to Mr. Selvers's evidence that, if the crane had been ordered immediately, hoisting might have begun as early as midnight. Mr. Hefkey was clearly unaware of the delays associated with ordering the crane.<sup>198</sup>

Just as important, it became evident during testimony that Mr. Hefkey, and therefore presumably all those involved in creating the MCSCS after-action report, seemed to think the Millennium crane was not able to lift the slabs that had fallen on Ms. Aylwin. He was not aware that the crane had been moving slabs and that there were only two left to move before reaching Ms. Aylwin:

- Q. Would you not agree, sir, that if the crane had been called earlier such that Mr. Selvers' crew had been able to be there, if you accept his evidence, up and hoisting by midnight on the 23rd, that that could have made a difference?
- A. So I go back to, again, I was not part of the detailed operations and the implementation of the tactics. But if the question is would that crane have assisted, well, again, it was there on the Sunday, and it was used. Again, when they looked at it, my understanding – and I stand to be corrected, but my understanding was that its capacity, it couldn't – given its limitations, it wasn't able to move the slabs ...
- ...
- A. Again, I go back to at that point in time, I'm sure that the individuals who were, again, looking after this operation didn't know it was just two slabs, and they –
- Q. The evidence, again, is that they thought it was only two slabs, so that there is a note when they pulled out that Sergeant Gillespie thought it was only two slabs, and there is a note in his book when they went back on the 27th, it was only two slabs.<sup>199</sup>

Mr. Hefkey also seemed confused about which crane was removing slabs, suggesting that the Priestly crane tried and could not move them. Commission counsel needed to correct his understanding and explain that the Millennium crane was removing slabs and actually had greater reach than the Priestly crane when it came to doing that type of work.<sup>200</sup> He eventually agreed that, in writing the report, he understood that the Millennium crane couldn't actually move slabs from the rubble pile: "It was my – yes ... that is my belief."<sup>201</sup>

Despite contradicting this evidence, Mr. Hefkey was still reluctant to agree that, if the crane had arrived earlier, it might have made a difference in recovering Ms. Aylwin. The following passage demonstrates clear confusion about the facts and an evident reluctance on the part of the ministry to accept the possibility that mistakes were made. When pressed on the fact that ordering the crane faster might have made a difference, Mr. Hefkey first, and wrongly, suggested that it did not because shoring needed to happen before the crane could be used. He then followed up with the suggestion that the crane did not matter because Ms. Aylwin died instantaneously:

- Q. When you wrote this report, it was your belief that the Millennium Crane was unable to lift slabs of concrete from the rubble pile?
- A. Yes.
- Q. Okay. Recognizing, if you could accept for a moment that that's incorrect – and we could play a video for you if you want to see it – that the Millennium Crane was, in fact, able to lift the slabs off and that when they did uncover Ms. Aylwin's body, they only had to lift two more slabs, do you agree with me that if the crane had got there earlier and had been able to commence earlier, that that might have made a difference to Ms. Aylwin?
- A. No.
- Q. Why not?
- A. Because I go back to the fact that they were – in fact, the rescuers when they were arriving there were actually working the pile, as was described before about there was shoring that was being done. There were activities that were being done. So as they were doing it, then the crane came at that point, and then it was able to effect what it was able to do.

Q. Well, sir, is what you are telling me based on what you think happened? Because the evidence that we have heard at this Commission is, as the Commissioner said, the crane was working, removing the slabs at the same time as the shoring was going on, and the UCRT crew was there in the evening of the 23rd and worked through the night of the 23rd and into the morning of the 24th, and throughout that time, they were both shoring and doing other things.

The crane didn't arrive until 11 o'clock in the morning on the 24th and couldn't get up and running for a few hours after that.

But if the crane had been there and up and working, able to do work by midnight on the 23rd, is it your evidence that you believe that that would not have made a difference to Ms. Aylwin?

A. Because then we find out that Ms. Aylwin perished minutes after.

Q. Well, sir, with respect, that is a question that the Commissioner is going to have to decide ...<sup>202</sup>

It was far from clear whose opinion Mr. Hefkey relied on to reach his conclusions. He mentioned having spoken to Chief Supt. Bruce from the OPP and the fire marshal, both individuals who were not actually on scene. In the end, he agreed that the Commission, after having heard the evidence first hand, was in a much better position to understand what actually occurred.<sup>203</sup>

Overall, I am left with serious concerns about the accuracy and reliability of the ministry's after-action report. It is based on misconceptions and errors about events during the operation. It starkly illustrates the consequences of failing to conduct proper debriefings and the importance of accurate record-keeping. It is difficult to resist the suspicion that its conclusions are, to some degree, motivated more by a desire to deflect criticism than to discover and acknowledge plain facts.

### **Despite confusion about the command structure in Elliot Lake, Mr. Hefkey feels the IMS appropriately placed the burden on the local municipality to establish the command structure**

Mr. Hefkey agreed that there was significant confusion during the Elliot Lake deployment over who was exercising the incident commander role and about the command structure generally.<sup>204</sup> It was pointed out to him that, even among the experts (UCRT and HUSAR/TF3), there was a lack of clarity about who played what role, whether there was a unified command structure or a single command, and what these concepts meant.<sup>205</sup>

In contrast with witnesses from the OPP and HUSAR/TF3, Mr. Hefkey felt the single command model should have been used in Elliot Lake because it was a "single site" and a "unidirectional or unidimensional" mission. His view of the appropriate command structure in Elliot Lake was as follows. Chief Officer was the incident commander. Staff Insp. Neadles was the chief of operations and reported to Chief Officer. Someone should have occupied the positions of planning chief, logistics chief, and finance and administration officer (perhaps the same person for all three positions), and those individuals (or that person) would have reported directly to Chief Officer instead of through Staff Insp. Neadles. If someone holding one of those positions needed a rest, a designated replacement should have been chosen. In addition, Mr. Hefkey agreed that it should have been clear to everybody involved who was occupying what position.<sup>206</sup>

Despite clear evidence that the rescue effort overwhelmed Elliot Lake's capacity, Mr. Hefkey told the Commission it was still his expectation that the local municipality, big or small, understands how to set up a proper command structure, no matter how complex and difficult the operation.<sup>207</sup>



Mr. Hefkey's answers reveal a potential shortcoming of the IMS when smaller municipalities find themselves faced with large-scale incidents and large rescue operations, as evidenced by the following exchange:

- Q. It is clear from the evidence, and it seems reasonable, that Chief Officer said this is beyond this town's capacity. We need to call in – I think in his evidence he said call in the experts. He called in the experts. Is it the expectation of the IMS team, the drafters, that Chief Officer would then decide who the Logistics Chief was, who the Planning Chief was, who the Operations Chief was, and they would all report to him?
- A. That is correct.
- Q. Did anybody ever tell Chief Officer that?
- A. That I don't know.
- Q. Certainly – and we'll look at the evidence, but certainly there seems to be no suggestion anywhere in the evidence that any of the members of TF-3 or UCRT told Chief Officer that he was supposed to put this team in place.
- A. That is correct.<sup>208</sup>

Mr. Hefkey continued on, saying there was a need to ensure that "every time we bring a provincial resource to bear on a municipal emergency, there is that clarity." He told the Commission that it should be possible for a local official such as Chief Officer to know who would be a good logistics chief, ops chief, planning chief, and finance chief by having "conversations ... before an incident." He felt that the people holding these positions did not need to be subject matter experts, but merely needed to communicate with the subject matter experts. Citing the "extensive Mutual Aid structure," he said the expectation was not that the municipality have all the resources necessary, but that it "reach out to their communities ... prior to the event," by which he meant reaching out to neighbouring towns.<sup>209</sup> Mr. Hefkey's insistence on the need for clarity is commendable and that goal is desirable. However, it will simply be clarity for clarity's sake if it is not accompanied by knowledge and expertise.

The very nature of catastrophic events is that they are unpredictable both in terms of time and scale. The immediacy and scale of an emergency such as the one in Elliot Lake will inevitably nearly overwhelm a small municipality's capabilities. When provincial resources are deployed, an expectation that a local fire chief or police chief, in the heat and confusion of a developing crisis, will in very short order designate the persons who are to occupy important IMS functions appears impractical to me. These are difficult decisions that should be left to trained experts. Surely the commander of a team such as HUSAR/TF3 or UCRT will have the expert knowledge and experience to at least suggest the identity of the holders of those responsible positions. Advance conversations in a mutual aid context may identify available common resources but cannot realistically be of much assistance in determining IMS roles. If the local responsible person is to remain the titular holder of the position of incident commander, what the IMS lacks, in my opinion, is the rapid deployment of expert advisory staff, seconded to command headquarters, to provide advice and to assist in the liaison with expert deployed resources.

### **Mr. Hefkey appears to misunderstand the appropriate command structure for UCRT/TF3 joint deployments**

As noted above, Mr. Hefkey explained the IMS expectation that the local municipality create the command structure for all emergency response operations, no matter how complicated. Ironically, Mr. Hefkey himself was not able to say what the appropriate command structure would be during a joint UCRT/TF3 deployment.

Mr. Hefkey was referred to Staff Insp. Needles's statement that UCRT fell under HUSAR/TF3 direction during joint operations. He was asked if this assumption was correct. Mr. Hefkey provided a rather convoluted answer, essentially saying his expectation was that different groups within operations, such as UCRT and HUSAR/TF3,

would interact frequently and have discussions about tactics. He did not agree that command automatically fell to HUSAR/TF3. He expected that HUSAR/TF3 and UCRT would have a “conversation” about the operations chief issue and, hopefully through additional training, the respective roles could be hammered out at some point during the deployment:

So here is my expectation. When these two teams deploy, my expectation is that they would have a conversation with each other and decide how are we going to wrestle this issue of Ops Chief, how are we going to wrestle that. And what we are hoping, and as you see one of our lessons learned is let's have more conversations, either through training, through exercises, or just through the interface between those two teams so they can have those conversations before the actual event.<sup>210</sup>

Mr. Hefkey agreed there was no protocol, written or unwritten, between UCRT and HUSAR/TF3 as to their command relationship during a joint deployment. He felt the only thing that mattered was that there be one person in the operations chief position. According to Mr. Hefkey, UCRT and HUSAR/TF3 should have had a conversation during the Elliot Lake deployment and come to an agreement on who held the operations chief position. HUSAR/TF3 erred in simply dictating the command structure to the OPP UCRT team.<sup>211</sup>

As Mr. Hefkey struggled with his explanation of the dynamics of the relationship between HUSAR/TF3 and UCRT and their determination of a command structure during a joint deployment, he appeared to have overlooked the very point he had previously attempted to make: Those decisions belong to the local incident commander.

### **Mr. Hefkey comments on additional errors in the application of IMS during the Elliot Lake deployment**

During his testimony, Mr. Hefkey referred to what he felt were additional terminological and practical errors in the application of the IMS during the Elliot Lake deployment.

As a first example, Mr. Hefkey felt that Cmdr. McCallion should not have referred to himself as the site commander. The term does not show up in IMS doctrine. It is a term that applies when there are many sites within the same municipality. In addition, it would be wrong to refer to Sgt. Gillespie as the operations section chief for his particular team – although he did maintain control over his unit.<sup>212</sup>

Mr. Hefkey also agreed that, because Chief Officer was the incident commander, he made the final decisions on the game plan for the rescue. Thus, when Staff Insp. Needles made the decision to put in shoring at 6:15 a.m. on June 24, without telling Chief Officer, this decision was a mistake. So, also, was Staff Insp. Needles's decision to stop the rescue mid-afternoon on June 25 without sharing the decision with Chief Officer until he later announced it at the Community Control Group meeting. Pursuant to IMS structure, Staff Insp. Needles, as operations chief, should have spoken to Chief Officer, as incident commander, and obtained his prior concurrence.<sup>213</sup>

Mr. Hefkey was also referred to the evidence of HUSAR/TF3's engineer, Mr. Cranford (who thought Capt. Comella, Staff Insp. Needles, and Cmdr. McCallion shared command but did not know their actual roles); and to that of the MOL engineer, Roger Jeffreys (who said he did not know who was in charge). Mr. Hefkey agreed there should have been a briefing before the rescue efforts began in which all of this information was set out. Because the decision to stop the rescue was based exclusively on engineering advice, Mr. Hefkey agreed it was all the more important that these individuals understood the command structure. He did not feel it was always necessary, though, for the engineers to give their advice directly to the operations chief and the incident commander. This approach might make sense if the information was complex and the individual conversing with the engineers, in this case Capt. Comella, was uncomfortable relaying it alone. He agreed there might be a “broken telephone” problem with too many intermediaries and that it was usually best to get information from the source. In terms

of best practices, the decision about whether to speak directly to the engineers was the incident commander's call to make.<sup>214</sup>

Mr. Hefkey was referred to Staff Insp. Neadles's evidence that there was no single planning chief – that the role was divided among himself, Cmdr. McCallion, and Capt. Comella. He said that, in order to avoid confusion, ideally there would be a single person in that position, and he agreed this situation was a serious deficiency during the Elliot Lake deployment.<sup>215</sup>

Mr. Hefkey also agreed that it was a mistake not to have created an incident action plan. One was supposed to have been created and updated for each operational period (or shift) in order to constantly re-evaluate the rescue efforts. The plan did not need to be elaborate, but would have been important because it allowed people to know what was expected of them and for an eventual analysis of the success of the mission.<sup>216</sup>

Another mistake, Mr. Hefkey said, was the absence of an initial command meeting, a step described by the IMS doctrine as "essential to provide key officials with an opportunity to discuss and concur on important issues." Even if brief, the meeting would be at a point in time when one should "document all important decisions and directions." The IMS doctrine describes the initial command meeting as an opportunity, *inter alia*, to discuss and agree on issues such as roles and responsibilities, jurisdictional boundaries, overall incident management organization, and senior appointments. Mr. Hefkey agreed that such a meeting would have helped sort things out in advance of the Elliot Lake rescue efforts.<sup>217</sup> He further agreed that briefings help facilitate information flow. The fact that UCRT did not brief HUSAR/TF3 on its arrival, and vice-versa during the mission, was a weakness.<sup>218</sup>

Mr. Hefkey further agreed that the IMS calls for a written incident action plan when the incident is a "complex incident."<sup>219</sup> The IMS doctrine defines that type of incident as having some or all of the following characteristics:

- prolonged duration that will require major changes in personnel or involve successive operational periods;
- large in scale, requiring a large number of resources;
- involving multiple jurisdictions;
- requiring special knowledge and/or training to resolve;
- posing a significant risk to the responders or the jurisdiction as a whole;
- having the potential to cause widespread damage or loss of life / injury;
- requiring a more complex organizational structure; and
- necessitating formal planning.<sup>220</sup>

Mr. Hefkey agreed that all these characteristics were present during the Elliot Lake deployment.<sup>221</sup> He also agreed that it would have been appropriate for a contingency plan to be in place before the decision was made to stop using the crane to remove slabs. The creation of such a plan typically falls to the planning chief under the IMS.<sup>222</sup>

Mr. Hefkey agreed that note-taking was important not only at the individual police officer or firefighter level, but also in terms of "incident documentation" showing what the plan was, the steps taken, what was achieved, and next steps. He agreed that none of the forms found in the IMS forms package was used during this incident, despite past efforts by the Office of the Fire Marshal and Emergency Management Ontario to share that documentation and to provide examples of what it looks like when filled out.<sup>223</sup>

On the importance of information management, the IMS doctrine refers to collection, collation, evaluation, and dissemination of information. Mr. Hefkey agreed this kind of management was something a planning chief would have ensured. He agreed that oral advice from the engineers, for example, created a problem for information management because it left no record and did not document and confirm that those who required the information received it. He agreed, as well, that it was a flaw in the information management situation.



Mr. Cranford had additional information about the ability to shore the failing beam with steel shoring, which he shared with no one. He gave only Capt. Comella information on the means to brace the escalator and beam against lateral forces. He told no one else. If the planning function had been clearly laid out and responsibility assigned, there ought to have been a system in place to capture that information.<sup>224</sup>

### **Mr. Hefkey accepts that the IMS being optional presented challenges, but does not agree that the system was overly complex**

Mr. Hefkey was questioned on the fact that the IMS was still only optional. Although he hesitated to admit that the ability to selectively pick and choose among IMS principles at an incident like Elliot Lake created a danger, he did agree that it created a “challenge” and that following all of the dictates of the IMS would make things safer.<sup>225</sup>

Mr. Hefkey was also initially reluctant to agree that the IMS was lengthy and complex. He thought the roles were fairly intuitive. He was pressed by Commission counsel on the apparent complexity of the IMS doctrine. I confess that I found his answer rather confusing:

- Q. And I said simpler because, using Inspector Needles as the example, he obviously is familiar with IMS, but had difficulties applying it in this particular situation. Without being critical of him, is one of the problems its apparent complexity, and could it not be made simpler?
- A. Well, and that is what we are going to do for us. We are going to go back to that same group who contributed to the document that we have been referring to, and we are going to ask them, say, Okay. We have got this issue. Folks are not applying the Incident Management System. How do we get to that culture of compliance so that people are actually using it and not just using it for the sake of we have created a rule, and so now it has to be so, but more we have got this document, and it makes good sense. It is sound operationally.
- And so for you, the person who would use this, perhaps not in a complex incident, but in a relatively simpler incident, that, you know what, yeah, it makes sense, and I see how I can work this and how I have got all of the aspects of incident management covered.
- Q. And I assume you'll be interested in what the Commissioner has to say on these issues as well?
- A. Yes. And that is why one of our lessons learned is to keep the committee who is working on these After-Action Reports and tracking and implementing our lessons learned, but the other role is for them to now take into consideration the recommendations coming from Phase II and the roundtables for the Commissioner and then seeing how those can be implemented.<sup>226</sup>

## **Ministry of Labour**

Apart from its report on the cause of the collapse, the Ministry of Labour did not produce a stand-alone after-action report related to its involvement in the rescue and recovery operations. The comments from MOL witnesses on areas for improvement were limited, but all agreed that they had never received training on the ministry role at the scene of an ongoing rescue. All three MOL witnesses essentially formulated their own opinions on the scope of their powers and when and how to exercise them.

## Notes

- <sup>1</sup> Comella testimony, September 4, 2013, pp. 24009–10.
- <sup>2</sup> Neadles testimony, September 12, 2013, pp. 25652–3.
- <sup>3</sup> Neadles testimony, September 12, 2013, pp. 25652–5; Glavin testimony, October 1, 2013, pp. 27746–7; Comella testimony, September 5, 2013, p. 24365; McCallion testimony, September 6, 2013, pp. 24665–6; McRae testimony, September 25, 2013, pp. 27265–6.
- <sup>4</sup> McCallion testimony, September 6, 2013, pp. 24665–6; Comella testimony, September 4, 2013, pp. 24010–11.
- <sup>5</sup> Neadles testimony, September 10, 2013, p. 25208.
- <sup>6</sup> Neadles testimony, September 12, 2013, pp. 25655–6; Neadles testimony, September 10, 2013, pp. 25208–9; Comella testimony, September 4, 2013, p. 24011.
- <sup>7</sup> Neadles testimony, September 12, 2013, pp. 25655–6; Neadles testimony, September 10, 2013, pp. 25209–10; Comella testimony, September 4, 2013, pp. 24011–12.
- <sup>8</sup> Comella testimony, September 4, 2013, pp. 24012–13.
- <sup>9</sup> Comella testimony, September 4, 2013, p. 24013.
- <sup>10</sup> McCallion testimony, September 6, 2013, pp. 24666–8; McRae testimony, September 25, 2013, pp. 27266–7.
- <sup>11</sup> Exhibit 7555.
- <sup>12</sup> Sorel testimony, October 1, 2013, pp. 27600–1.
- <sup>13</sup> Sorel testimony, October 1, 2013, pp. 27601–5, 27608 and 27612–13.
- <sup>14</sup> Neadles testimony, September 12, 2013, pp. 25666–7.
- <sup>15</sup> Exhibit 7555.
- <sup>16</sup> Exhibit 7555.
- <sup>17</sup> Neadles testimony, September 12, 2013, pp. 25673–6; McCallion testimony, September 6, 2013, p. 24687.
- <sup>18</sup> Exhibit 7581.
- <sup>19</sup> Comella testimony, September 5, 2013, p. 24316.
- <sup>20</sup> Neadles testimony, September 12, 2013, p. 25658.
- <sup>21</sup> Neadles testimony, September 12, 2013, pp. 25656–8.
- <sup>22</sup> McRae testimony, September 25, 2013, pp. 27267–8.
- <sup>23</sup> McCallion testimony, September 6, 2013, p. 24699.
- <sup>24</sup> Exhibit 7585; Sorel testimony, October 1, 2013, pp. 27594–5.
- <sup>25</sup> Glavin testimony, October 1, 2013, pp. 27747–50.
- <sup>26</sup> Comella testimony, September 5, 2013, pp. 24319–21.
- <sup>27</sup> Exhibit 7584.
- <sup>28</sup> Comella testimony, September 5, 2013, pp. 24320–1.
- <sup>29</sup> Comella testimony, September 5, 2013, pp. 24322–3.
- <sup>30</sup> Exhibit 7816; Comella testimony, September 5, 2013, pp. 24323–4.
- <sup>31</sup> Exhibit 7816.
- <sup>32</sup> Exhibit 7816.
- <sup>33</sup> Exhibit 7816.
- <sup>34</sup> Comella testimony, September 5, 2013, p. 24367.
- <sup>35</sup> Exhibit 7588.
- <sup>36</sup> Exhibit 7588.
- <sup>37</sup> Exhibit 7588.
- <sup>38</sup> Exhibit 7588.
- <sup>39</sup> Exhibit 7588.
- <sup>40</sup> Neadles testimony, September 12, 2013, p. 25660.
- <sup>41</sup> Exhibit 7588.
- <sup>42</sup> Exhibit 7588.
- <sup>43</sup> Neadles testimony, September 12, 2013, pp. 25668–70; September 10, 2013, pp. 25217–18.
- <sup>44</sup> Neadles testimony, September 12, 2013, pp. 25670–1; September 10, 2013, pp. 25216–17.
- <sup>45</sup> Neadles testimony, September 10, 2013, p. 25219.
- <sup>46</sup> Neadles testimony, September 10, 2013, pp. 25219–20.
- <sup>47</sup> Neadles testimony, September 12, 2013, pp. 25676–7.
- <sup>48</sup> Neadles testimony, September 12, 2013, pp. 25674–6.
- <sup>49</sup> Neadles testimony, September 12, 2013, pp. 25677–80.
- <sup>50</sup> McCallion testimony, September 6, 2013, p. 24670.
- <sup>51</sup> McCallion testimony, September 6, 2013, pp. 24671–2.
- <sup>52</sup> McCallion testimony, September 6, 2013, pp. 24676–7.
- <sup>53</sup> McCallion testimony, September 12, 2013, pp. 24672–6.
- <sup>54</sup> Comella testimony, September 5, 2013, p. 24317.
- <sup>55</sup> Comella testimony, September 5, 2013, p. 24317.
- <sup>56</sup> Comella testimony, September 5, 2013, pp. 24317–18.
- <sup>57</sup> McRae testimony, September 25, 2013, pp. 27269–70.
- <sup>58</sup> Glavin testimony, October 1, 2013, pp. 27750–2.
- <sup>59</sup> Glavin testimony, October 1, 2013, pp. 27752–5.
- <sup>60</sup> Guy testimony, September 24, 2013, pp. 27139–43.
- <sup>61</sup> Exhibit 7554. See Exhibit 7579 for Sgt. Gillespie's list of UCRT members in attendance at the Elliot Lake deployment.
- <sup>62</sup> Exhibit 7554. All references in this subsection are to this document unless otherwise noted.
- <sup>63</sup> Jacklin testimony, August 27, 2013, pp. 22652–3.
- <sup>64</sup> Jacklin testimony, August 27, 2013, p. 22659.
- <sup>65</sup> See, also, Bailey testimony, August 27, 2013, pp. 22818–21.
- <sup>66</sup> Bailey testimony, August 27, 2013, p. 22832.
- <sup>67</sup> Cox testimony, August 26, 2013, pp. 22434–5.
- <sup>68</sup> Hulsman testimony, August 28, 2013, pp. 23085–6.
- <sup>69</sup> Hulsman testimony, August 28, 2013, pp. 23086–7.
- <sup>70</sup> Hulsman testimony, August 28, 2013, pp. 23087–9.
- <sup>71</sup> Exhibit 7579; Gillespie testimony, September 3, 2013, p. 23800.
- <sup>72</sup> Exhibit 7579.
- <sup>73</sup> Gillespie testimony, September 3, 2013, pp. 23800–1.
- <sup>74</sup> Gillespie testimony, September 3, 2013, p. 23803.
- <sup>75</sup> Exhibit 7784.
- <sup>76</sup> Exhibit 7784, p. 005.
- <sup>77</sup> Exhibit 7784, p. 005.
- <sup>78</sup> Exhibit 7784, pp. 011–12.
- <sup>79</sup> Exhibit 7784, p. 009.
- <sup>80</sup> Exhibit 7784, p. 009.
- <sup>81</sup> Exhibit 7784, pp. 009–010.
- <sup>82</sup> Exhibit 7784, p. 010.
- <sup>83</sup> Exhibit 7784, p. 013.
- <sup>84</sup> Exhibit 7784, p. 005.
- <sup>85</sup> Exhibit 7784, p. 014–15.
- <sup>86</sup> Exhibit 7784, p. 005.
- <sup>87</sup> Exhibit 7784, p. 015.
- <sup>88</sup> Jollymore testimony, September 24, 2013, pp. 26951–3.
- <sup>89</sup> Exhibit 7784, p. 015.
- <sup>90</sup> Exhibit 7784, p. 015–16.
- <sup>91</sup> Jollymore testimony, September 24, 2013, pp. 26951–3.
- <sup>92</sup> Jollymore testimony, September 24, 2013, pp. 26957–8.
- <sup>93</sup> Exhibit 7784, p. 016.
- <sup>94</sup> Gillespie testimony, September 4, 2013, pp. 23823–4.
- <sup>95</sup> Exhibit 7784, pp. 016–17.
- <sup>96</sup> Gillespie testimony, September 3, 2013, p. 23796.
- <sup>97</sup> Gillespie testimony, September 3, 2013, pp. 23797–8.
- <sup>98</sup> Exhibit 7784, pp. 016–17.
- <sup>99</sup> Exhibit 7784, p. 017.
- <sup>100</sup> Exhibit 7784, p. 019.
- <sup>101</sup> Exhibit 7784, pp. 019–20.

- <sup>102</sup> Bruce testimony, August 23, 2013, pp. 22132–3.
- <sup>103</sup> Bruce testimony, August 23, 2013, p. 22137.
- <sup>104</sup> Bruce testimony, August 23, 2013, pp. 22137–8.
- <sup>105</sup> Bruce testimony, August 23, 2013, p. 22141.
- <sup>106</sup> Bruce testimony, August 23, 2013, p. 22142.
- <sup>107</sup> Bruce testimony, August 23, 2013, pp. 22184–7.
- <sup>108</sup> Bruce testimony, August 23, 2013, pp. 22146–8; Jacklin testimony, August 27, 2013, pp. 22653–4.
- <sup>109</sup> Bruce testimony, August 23, 2013, pp. 22150–1; Jacklin testimony, August 23, 2013, pp. 22147–9; Jacklin testimony, August 27, 2013, p. 22653.
- <sup>110</sup> Jacklin testimony, August 27, 2013, pp. 22653–4.
- <sup>111</sup> Bruce testimony, August 23, 2013, pp. 22150–1.
- <sup>112</sup> Bruce testimony, August 23, 2013, pp. 22159 and 22162.
- <sup>113</sup> Bruce testimony, August 23, 2013, p. 22180.
- <sup>114</sup> Bruce testimony, August 23, 2013, pp. 22181–3.
- <sup>115</sup> Hamilton testimony, October 7, 2013, p. 28555.
- <sup>116</sup> Exhibit 8090, p. 042.
- <sup>117</sup> Hamilton testimony, October 7, 2013, pp. 28555–6.
- <sup>118</sup> deBortoli testimony, October 7, 2013, p. 28466.
- <sup>119</sup> Exhibit 9892.
- <sup>120</sup> deBortoli testimony, October 7, 2013, p. 28466.
- <sup>121</sup> Exhibit 9892.
- <sup>122</sup> deBortoli testimony, October 7, 2013, p. 28466.
- <sup>123</sup> Rheume testimony, September 26, 2013, pp. 27511–4.
- <sup>124</sup> Hamilton testimony, October 7, 2013, pp. 28560–1.
- <sup>125</sup> Hamilton testimony, October 7, 2013, p. 28566.
- <sup>126</sup> Hamilton testimony, October 7, 2013, pp. 28560–1.
- <sup>127</sup> Hamilton testimony, October 7, 2013, pp. 28562–4.
- <sup>128</sup> Rheume testimony, September 26, 2013, pp. 27514–15.
- <sup>129</sup> deBortoli testimony, October 7, 2013, pp. 28467–8.
- <sup>130</sup> Officer testimony, August 22, 2013, pp. 21863–4.
- <sup>131</sup> Officer testimony, August 22, 2013, pp. 21864–6.
- <sup>132</sup> Officer testimony, August 22, 2013, p. 21868.
- <sup>133</sup> Officer testimony, August 22, 2013, pp. 21868–9.
- <sup>134</sup> Officer testimony, August 22, 2013, p. 21870. See Exhibit 7510 for Chief Officer's press release thanking UCRT.
- <sup>135</sup> Officer testimony, August 22, 2013, pp. 21870–2.
- <sup>136</sup> Officer testimony, September 19, 2013, pp. 26406–7.
- <sup>137</sup> Officer testimony, August 22, 2013, p. 21873.
- <sup>138</sup> Thomas testimony, August 20, 2013, pp. 21166–71 and 21206–7.
- <sup>139</sup> Thomas testimony, August 20, 2013, pp. 21166–71 and 21206–7.
- <sup>140</sup> Chambers testimony, September 18, 2013, pp. 26204–6.
- <sup>141</sup> Exhibit 7785.
- <sup>142</sup> Exhibit 7785.
- <sup>143</sup> Exhibit 7785.
- <sup>144</sup> Exhibit 7785.
- <sup>145</sup> Exhibit 7785.
- <sup>146</sup> Exhibit 7785.
- <sup>147</sup> Exhibit 7785.
- <sup>148</sup> Exhibit 7785.
- <sup>149</sup> Exhibit 6402.
- <sup>150</sup> Kerr testimony, September 25, 2013, p. 27356.
- <sup>151</sup> Kerr testimony, September 25, 2013, pp. 27356–8.
- <sup>152</sup> Kerr testimony, September 25, 2013, pp. 27341–4.
- <sup>153</sup> Kerr testimony, September 25, 2013, pp. 27356–8.
- <sup>154</sup> Kerr testimony, September 25, 2013, pp. 27350–1.
- <sup>155</sup> Kerr testimony, September 25, 2013, pp. 27359–60.
- <sup>156</sup> Kerr testimony, September 25, 2013, pp. 27359–60.
- <sup>157</sup> Latulippe testimony, August 7, 2013, p. 19937.
- <sup>158</sup> Latulippe testimony, August 7, 2013, pp. 19938–9.
- <sup>159</sup> Latulippe testimony, August 7, 2013, p. 19939.
- <sup>160</sup> Réjean Aylwin testimony, August 7, 2013, p. 19995.
- <sup>161</sup> Latulippe testimony, August 7, 2013, p. 19940.
- <sup>162</sup> Gendron testimony, August 8, 2013, pp. 20053–5.
- <sup>163</sup> Gendron testimony, August 8, 2013, pp. 20053–5.
- <sup>164</sup> Gendron testimony, August 8, 2013, pp. 20055–6.
- <sup>165</sup> Jollymore testimony, September 24, 2013, pp. 27024–5.
- <sup>166</sup> Jollymore testimony, September 24, 2013, p. 27026.
- <sup>167</sup> Exhibit 6246.
- <sup>168</sup> Exhibit 6246, pp. 002–003.
- <sup>169</sup> Exhibit 6246, p. 011.
- <sup>170</sup> Exhibit 6246, p. 013.
- <sup>171</sup> Selvers testimony, September 10, 2013, pp. 25104–5.
- <sup>172</sup> Exhibit 6246, pp. 007, 012, 013.
- <sup>173</sup> Exhibit 6246, pp. 010, 012 and 013.
- <sup>174</sup> Selvers testimony, September 10, 2013, pp. 25118–21.
- <sup>175</sup> Selvers testimony, September 10, 2013, p. 25121.
- <sup>176</sup> Selvers testimony, September 10, 2013, pp. 25110–11.
- <sup>177</sup> Selvers testimony, September 10, 2013, pp. 25227–8.
- <sup>178</sup> Neadles testimony, September 12, 2013, pp. 25681–2.
- <sup>179</sup> Neadles testimony, September 12, 2013, p. 25699.
- <sup>180</sup> Neadles testimony, September 12, 2013, pp. 25684–7.
- <sup>181</sup> Neadles testimony, September 12, 2013, pp. 25688–704.
- <sup>182</sup> Exhibit 9912.
- <sup>183</sup> Hefkey testimony, October 8, 2013, pp. 28658–60.
- <sup>184</sup> Exhibit 9912, p. 002.
- <sup>185</sup> Exhibit 9912, pp. 006–007.
- <sup>186</sup> Exhibit 9912, pp. 008–009.
- <sup>187</sup> Exhibit 9912, pp. 009–10.
- <sup>188</sup> Exhibit 9912, p. 011.
- <sup>189</sup> Exhibit 9912, pp. 011–12.
- <sup>190</sup> Exhibit 9912, p. 012.
- <sup>191</sup> Exhibit 9912, pp. 012–13.
- <sup>192</sup> Exhibit 9912, p. 014.
- <sup>193</sup> Exhibit 9912.
- <sup>194</sup> Hefkey testimony, October 8, 2013, pp. 28661–3.
- <sup>195</sup> Hefkey testimony, October 8, 2013, pp. 28662–5.
- <sup>196</sup> Hefkey testimony, October 8, 2013, pp. 28665–7.
- <sup>197</sup> Hefkey testimony, October 8, 2013, pp. 28668–70.
- <sup>198</sup> Hefkey testimony, October 8, 2013, pp. 28671–5.
- <sup>199</sup> Hefkey testimony, October 8, 2013, pp. 28671–5.
- <sup>200</sup> Hefkey testimony, October 8, 2013, pp. 28678–9.
- <sup>201</sup> Hefkey testimony, October 8, 2013, pp. 28682 and 28684.
- <sup>202</sup> Hefkey testimony, October 8, 2013, pp. 28684–7.
- <sup>203</sup> Hefkey testimony, October 8, 2013, pp. 28684–8.
- <sup>204</sup> Hefkey testimony, October 8, 2013, pp. 28693–7.
- <sup>205</sup> Hefkey testimony, October 8, 2013, pp. 28704–9.
- <sup>206</sup> Hefkey testimony, October 8, 2013, pp. 28704–9.
- <sup>207</sup> Hefkey testimony, October 8, 2013, pp. 28693–7.
- <sup>208</sup> Hefkey testimony, October 8, 2013, pp. 28693–7.
- <sup>209</sup> Hefkey testimony, October 8, 2013, pp. 28697–9.
- <sup>210</sup> Hefkey testimony, October 8, 2013, pp. 28710–2.
- <sup>211</sup> Hefkey testimony, October 8, 2013, pp. 28712–16.
- <sup>212</sup> Hefkey testimony, October 8, 2013, pp. 28716–18.
- <sup>213</sup> Hefkey testimony, October 8, 2013, pp. 28718–20.
- <sup>214</sup> Hefkey testimony, October 8, 2013, pp. 28720–5.
- <sup>215</sup> Hefkey testimony, October 8, 2013, pp. 28726, 28740.
- <sup>216</sup> Hefkey testimony, October 8, 2013, pp. 28728–31.



<sup>217</sup> Hefkey testimony, October 8, 2013, pp. 28742–4; Exhibit 887, p. 059.

<sup>218</sup> Hefkey testimony, October 8, 2013, p. 28748.

<sup>219</sup> Hefkey testimony, October 8, 2013, p. 28741.

<sup>220</sup> Exhibit 887, p. 055.

<sup>221</sup> Hefkey testimony, October 8, 2013, p. 28742.

<sup>222</sup> Hefkey testimony, October 8, 2013, pp. 28731–3.

<sup>223</sup> Hefkey testimony, October 8, 2013, pp. 28734–6.

<sup>224</sup> Hefkey testimony, October 8, 2013, pp. 28744–8; Exhibit 887, p. 071.

<sup>225</sup> Hefkey testimony, October 8, 2013, pp. 28758–60.

<sup>226</sup> Hefkey testimony, October 8, 2013, pp. 28760–4.

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*If I have seen further than others,  
it is by standing upon the shoulders of giants.*

Isaac Newton



Experience is clearly the best teacher. Emergency response organizations are not static entities – their composition evolves constantly as newer members replace older ones. Methods and procedures are refined through experience. New protocols emerge. New technologies become available. Training opportunities multiply. In the process, knowledge accumulates. The preservation and dissemination of that accumulated knowledge is essential to ensure effectiveness and efficiency when emergencies occur. No two emergencies will be identical. In that sense, like old generals, we are always prepared to re-fight the last battle but often ill-prepared to win the next. To ensure that we do not repeat the mistakes of others but benefit from the knowledge of their successes and failures, we need to document carefully lessons learned and pass them along to our successors. Thus do we achieve excellence.

I do not consider the thrust of this analysis to be an exercise in negativity, blame, and criticism. If I point out what I think was less than ideal in the Elliot Lake rescue and recovery effort, it is only with a view to ensuring that things will be done better the next time. Of this I entertain not the slightest reservation: All those involved in the aftermath of the Elliot Lake disaster acted with sincere passion and earnest commitment to achieve one goal – rescuing potential survivors.

**All those involved in the aftermath of the Elliot Lake disaster acted with sincere passion and earnest commitment to achieve one goal – rescuing potential survivors.**

## **The time of death – could a different or more rapid response have made a difference?**

It is clear to me that Doloris Perizzolo's death was nearly instantaneous after the collapse. The catastrophic injuries that she received could not possibly have allowed her to survive for any appreciable period of time. However, on all the evidence before me, I believe that it is probable (although by no means certain) that Lucie Aylwin survived the collapse for a period of approximately 39 hours. In a sense, it is bitterly ironic to fervently hope that I am wrong and that the medical evidence is right – that her death occurred a mercifully short time after she was buried in the rubble. Clearly, after 5 a.m. on June 25, it is most unlikely that she was still alive.

The medical evidence I have heard supports the proposition that Lucie Aylwin's injuries were severe, sufficiently so that she likely did not survive the collapse by any significant length of time. But not one of these injuries, taken by itself, was necessarily and irrefutably fatal. Tantalizing signs of her survival appear to contradict the medical evidence. The apparently responsive tapping in reaction to calling out, the muffled voice heard by the responders, and the recurring positive indications given by the well-trained dogs searching the debris pile with their experienced handlers encouraged rescuers and fuelled their efforts. The LifeLocator also gave apparently positive results, but these are ultimately of little value, given the manner in which it was used and the implausibility of some of the readings.

The medical evidence that I review at length earlier in the Report is such that, if it is correct, all the evidence of signs of life testified to by a number of witnesses would have to be discounted. It would be the oddest of coincidences that all signs of life originated precisely where Ms. Aylwin's body was recovered.

Complicating the issue is the fact that the medical evidence is that death was said to likely be near immediate after crushing forces were applied. What I do not know is *when* those crushing forces were applied: immediately after the collapse? or after some later shift in the debris pile overlying her body? I have heard no evidence that there was such a shift, though the possibility exists that one occurred later.

People have often survived similar collapses and have been recovered alive for periods well in excess of the time period with which I am concerned. There were voids in the concrete pile and there likely was water close by. If Lucie Aylwin did survive after the initial collapse, the question will always recur: Had the rescue effort been done in a different way, had it been more rapidly executed, could she have been rescued?

The answer to that question will have to be a vague "maybe" or an imprecise "perhaps." I know that is unsatisfactory, but I cannot provide a better answer.

## The speed of the response

Critical to the actions that followed the collapse was the rapid mobilization of emergency and rescue organizations. Time was clearly of the essence. Common sense and the medical evidence presented to the Commission make plain that, if a victim survived the initial trauma of the collapse and was trapped under the rubble, the chances of survival diminished as time advanced. Initially, no one knew who might be injured or trapped in the rubble. The nature of the event clearly required stabilization of the scene, reconnaissance, and dissemination of information.

### The Elliot Lake Fire Department, the OPP, the Community Control Group, and the province – rapid and appropriate responses

The Elliot Lake Fire Department's response was prompt and efficient when it arrived on scene a bare few minutes after the collapse. As a first course of action, the firefighters shut off the utilities, thereby eliminating an additional source of danger to a situation that was already unsafe. Chief Paul Officer very quickly activated the Community Control Group (CCG) and contacted the Office of the Fire Marshal (OFM). He set up a command post. The department's accountability system appears to have performed as intended. Tracking of all responding personnel by placing a board against a truck parked immediately in front of the Mall was a simple and effective method of determining the whereabouts of all responders who placed their tags in the "In" or "Out" column opposite their names as they entered or left the hot zone. The chief's instructions to reconnoitre, post spotters, and secure the site were rapid and appropriate. Reconnaissance of the collapse area was quickly carried out to ensure rapid evacuation of the Mall and to render assistance to those who might be injured.

Chief Officer quickly recognized that coping with the emergency was beyond his forces' capabilities and requested the Heavy Urban Search and Rescue Task Force 3 (HUSAR/TF3) activation as well as the mutual aid protocol with Blind River. Although Chief Officer mistakenly felt he could not contact the Provincial Emergency Operations Centre (PEOC) to request HUSAR/TF3 assistance until the City made a formal declaration of emergency, no delay was occasioned by that misconception. In any event, a declaration of emergency was made in a timely fashion.

In my view, dissemination of vital information and notification to all important authorities and ministries was rapid and efficient.

The OPP UCRT (Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) team left Bolton less than two hours after notification of the collapse and arrived in Elliot Lake between approximately 9:00 and 9:30 p.m. It is my view that the speed of that deployment was remarkable.

All in all, the initial reaction to the collapse was appropriate.

## **HUSAR/TF3 – could it have deployed more quickly?**

HUSAR/TF3 has a mandated “stand-up time,” or mobilization time, of six hours after receiving orders to deploy.

I assume that mandated time to mean that mobilization should not take *more* time to deploy than six hours – an outside limit. Surely, no one would disagree that a shorter deployment time would, if achievable, be desirable. Staff Insp. William Neadles was given the order to deploy HUSAR/TF3 at 4:21 p.m. on June 23, but there had been advance notice of the impending deployment. Slightly before 4 p.m., Capt. Martin McRae knew that the team would be deployed. The loaded tractor trailers left the home of operations at 9:56 p.m. to meet up with the bus transporting the rescuers. Mobilization, therefore, occurred within the six-hour stand-up time. Could it have been done more quickly? Perhaps. The pace certainly does not appear to have been frenetic. Some things could have been done more rapidly, but I cannot say with certainty that they affected the group’s departure time.

Specifically, I note that

- It was only at 5:05 p.m. that Capt. McRae called Paul Demy, HUSAR/TF3’s main driver, and instructed him to arrange for the rental of the tractors, as well as obtaining drivers. The team does not own its own tractors.
- There were problems obtaining tractors. The only ones available were located in Mississauga, approximately 25 kilometres away. The drivers left the home of operations at 6:08 p.m. They arrived back at 8:10 p.m., more than four hours after it was learned that there would be a deployment.
- HUSAR/TF3 also did not have designated drivers who possessed the proper qualifications. They were obtained through Don Sorel of Toronto Water (who advised that they would not be obtained from that source in the future as one driver was injured in the deployment). I have not heard evidence of how HUSAR/TF3 currently deals with that issue.
- All team members were required to undergo a brief medical examination at the muster point. I understand the rationale for a cursory examination. One would not want a sick responder to infect the other team members and reduce the team’s effectiveness. But when time is crucial, surely one could assume that someone who is sick will act responsibly, self-report, and decline deployment. Summoning a medical practitioner, a paramedic, or a nurse and carrying out an examination of 30-plus responders must take some time (albeit no evidence was called to describe who was examined, by whom, and the nature of the examination). In fairness, I have heard no evidence showing that the process delayed departure, but if it did, its necessity ought to be revisited.
- The cube van was loaded with 100 kit bags at the home of operations and ready to go to the muster point only at 7:57 p.m. It left at 8:05 p.m. and arrived at the muster point at 8:28 p.m. Capt. McRae testified that the task could reasonably be done in under an hour. I heard no evidence justifying the delay.



- On June 23, members of HUSAR/TF3 were on a training exercise in Rouge Valley. They were assembled on location, and their bus left at 4:50 p.m. to arrive at the home of operations at 5:35 p.m.. At that location, they picked up their vehicles, returned home to pick up their gear, and returned to their muster point where, at 9:15 p.m., they picked up their kits. They left the muster point by bus at 9:30 p.m. to meet up with the tractor trailers and convoy up to Elliot Lake.
- All in all, it may be that the difficulties and delays I have mentioned delayed the group's departure somewhat, but quantifying time lost is difficult. At 8:23 p.m., Staff Insp. Neadles informed Carol-Lynn Chambers, the manager of Emergency Planning and Strategic Development, OFM, that the departure would be held up by at least 30 to 60 minutes because of a tractor delay. Even if it had not encountered problems getting the rental tractors, the team would not have been ready to leave at 8:30 p.m. because issuing the kits to the team members was finished only at 9:15 p.m.

## **Deployment numbers could have been higher**

### **HUSAR/TF3 – less than half, and no planning section chief**

A full HUSAR/TF3 deployment consists of 76 team members plus eight drivers, with a task force / site commander in overall charge and section chiefs for each of the main Incident Management System (IMS) categories: operations, planning, logistics, and finance / administration. In fact, only 33 team members and three drivers deployed.

Staff Insp. Neadles was in overall command. Capt. Tony Comella described his own role, from time to time, as being safety officer, operations section chief (which he viewed as an advisory function only), and occasional planning section chief. Cmdr. Michael McCallion expected that he was being deployed as the medical manager but became a site commander in Elliot Lake, alternating for Staff Insp. Neadles. Capt. McRae was used mostly as logistics section chief.

The planning section chief who should have been deployed was not available. This situation undoubtedly contributed to the lack of planning I have described elsewhere in this Report.

### **UCRT – less than half, and no staff sergeant**

On the day of the collapse, the ideal UCRT available complement was 23 with a staff sergeant as unit commander, an urban search and rescue sergeant, and an administrative / operational support sergeant. In fact, however, only 10 members and two medics were actually deployed, with Cst. Ryan Cox in charge until Sgt. Jamie Gillespie could attend. There was no staff sergeant available. This situation meant that an officer could not be both in the command tent to take part in planning discussions and in the hot zone to supervise the work being done.

In my opinion, the fact that the actual number of responders who went to Elliot Lake was less than half of potential was not, in and of itself, the cause of the difficulties experienced in the rescue. Rather, as I will describe below, the problem was not with the workers in the hot zone, but with the poor dynamics of the command structure, fundamental misunderstandings about the role of individuals within that structure, and the failure to implement IMS as it was designed.

## The rescue operation

The Incident Management System (IMS) is an ideal construct, a model designed to be scaled and adapted to the imperatives of any particular emergency response. Both UCRT and HUSAR/TF3 personnel were extensively trained in its theory and application. Other organizations, such as the Elliot Lake Fire Department, possessed at least passing familiarity with its concepts. And yet, despite its inculcation across the broad spectrum of all emergency responders, its application to the Elliot Lake emergency was very much wanting.

### No incident action plan

One of the most important tenets of the IMS is the establishment of an incident action plan. It is to be developed by the Planning Section but is approved by the incident commander.

As stated previously, the purpose of the plan is to provide all incident supervisory personnel with direction for the actions that are to be implemented in the course of the emergency response. A written plan should be used when dealing with complex incidents and should be developed at a planning meeting. It should be followed by an operations briefing to ensure that everyone in the emergency response structure is aware of the strategy and tactics that will be employed in the execution of the plan.

Under IMS, the Planning Section is intended to develop the incident action plan and may include roles such as collecting, evaluating, analyzing, and disseminating information related to the emergency response. The Planning Section's roles could also include maintaining incident documentation, tracking resources assigned to the incident, and conducting long-range and/or contingency planning.

And yet, I have heard no evidence of the development of an incident action plan. One may have existed as a concept in the minds of Staff Insp. Neadles, Cmdr. McCallion, or Capt. Comella, but it was certainly not reduced to writing in any form. Chief Officer, as incident commander, was not involved in the development of a plan in any way. It was not the subject of a briefing to the individuals who made up the rescue teams or explained to others whose expertise could have helped: the HUSAR/TF3 engineer, James Cranford, for example; or to Ministry of Labour personnel on site, such as provincial engineer Roger Jeffreys. Accomplished tasks and tasks left to be performed were not posted anywhere. Contingencies and alternatives were not outlined, even in rudimentary form.

The Elliot Lake Fire Department, HUSAR/TF3, and UCRT have all adopted the IMS as their emergency management tool but, in fairness, none of its features is mandatory. And yet, in a complex rescue operation such as the one in Elliot Lake, it seems to me that the creation of an action plan should have been a top priority. The failure to do so flawed the emergency response.

A simple whiteboard in a prominent command location outlining the mission's incident action plan would have been a rapid and convenient method of informing all participants of the mission's progress, of achieved objectives, and of projected action. In Elliot Lake, there was no written action plan promulgated and positioned for all to see. Systematic shift-change briefings did not occur regularly, leaving many individual responders in the dark about the overall objectives of the exercise.

A written action plan was eventually produced, but not by anyone in the command structure – it was drafted and executed by crane operator Ryan Priestly after his equipment was ordered.

**... in a complex rescue operation such as the one in Elliot Lake, it seems to me that the creation of an action plan should have been a top priority. The failure to do so flawed the emergency response.**

## **No one properly understood the command structure or the role of supporting organizations**

There was widespread confusion about the identity and role of the incident commander. Even those who understood who the incident commander was nevertheless made important decisions without consulting him. The confusion permeated all who were involved in the rescue operation, beginning with Chief Officer. But he was far from being alone. Staff Insp. Neadles took on the role of incident commander and communications spokesperson. Communications from the Premier's Office and from Dan Hefkey, the commissioner for community safety, bypassed Chief Officer completely after the rescue operation was initially called off. Mr. Cranford, the HUSAR/TF3 embedded engineer, admitted he did not know who the incident commander was. He thought that he reported to Capt. Comella, and, through the muddle, his plan to shore up the beam supporting the escalator was never communicated up the chain of command. Insp. Percy Jollymore at one point declared himself the incident commander.

## **Lack of understanding and agreement between HUSAR/TF3 and UCRT**

Before the Elliot Lake collapse, there was no protocol or understanding about the nature of the relationship between HUSAR/TF3 and UCRT when they jointly responded. HUSAR/TF3 leaders assumed that, once their team was on site, they would be in overall command of operations. UCRT would simply be an alternative team working on the pile. Being relegated to this function created ill-feeling and confusion. UCRT had no presence in the command tent and no voice in the elaboration of strategy and in the eventual decision to stop the rescue.

## **Cranes and rigging operations could have started sooner**

Despite a very early request by Cst. Cox for a crane, one was ordered only at the end of the day on June 23. Millennium Crane's owner and operator Dave Selvers could have put his equipment on the road much earlier, but the late call made gathering of his forces and equipment more difficult. Similarly, there was evidence that, once a decision was made to use the Priestly equipment, the request for its mobilization could have been made more quickly.

Staff Insp. Neadles seems to have played no role in the decision to involve the Millennium Crane in rigging operations.

In effect, very little progress in reaching Ms. Aylwin and removing the material overlying her body was achieved by HUSAR/TF3, other than by participating in the crane and rigging operation suggested by UCRT. The Elliot Lake Fire Department members were initially on the debris pile removing materials, but were called off because of safety concerns. The same concerns caused the ceasing of the Millennium crane operations. Only the Priestly equipment finally managed to remove that debris on the early morning of June 27. By that time, Ms. Aylwin had surely died. The shoring operations performed by HUSAR/TF3 and the "tunnelling" toward the debris pile ultimately achieved very little. There seemed to be no purpose to the construction of shoring within the Mall except to get safely to the debris pile, but I heard of no plan about what was to be done once the team got there.

There appears to be an ingrained reluctance on the part of HUSAR/TF3 to consider the utility and effectiveness of using cranes in structural-collapse events. At best, the use of cranes is considered a last resort. Only Mr. Sorel had training and expertise in this area. Certainly, HUSAR/TF3 training in this area is non-existent or very limited.

Staff Insp. Neadles knew of Priestly Demolition's existence and its capabilities even before Sgt. Phil Glavin refreshed his memory after the rescue was called off. Even then, resort to Priestly's services came only after the intervention of the Premier's Office.



## Little or no record-keeping or contemporaneous note-taking

A major problem encountered by Commission counsel in its task of presenting evidence to the Commission was the poor state of contemporary record-keeping as the operation developed. The Community Control Group had a scribe assigned from the outset – and a record was maintained – but the two principal rescue groups, HUSAR/TF3 and UCRT, did not have a scribe. Memories were left to be refreshed only by the notes of individuals involved in the rescue effort. Unfortunately, most of these notes were not contemporaneous. They were created long after the events they purported to record. The difficulty is understandable. Maintaining a contemporaneous record as one's efforts are directed at the prime objective of rescuing individuals is not the first priority. Compiling notes at shift end, when one is exhausted, both physically and mentally, is not easy. In those circumstances, it is not surprising that evidence conflicted in relation to the timing and nature of significant events. The lack of properly kept notes is evident when one attempts to decipher the sequence of events following the noon press conference on June 25. Everyone – Chief Officer, Staff Insp. Neadles, Cmdr. McCallion, Capt. Comella, the engineers, and others – gave differing accounts of what led to the decision to order everyone out of the building.

Of course, the need for accurate record-keeping is not to assist the Commission in its attempt to recreate an accurate narrative. Its importance lies in its instructional value for future responders. Assigning scribes to accompany the important players during the Elliot Lake operation should not have been difficult. It is not a task that requires special training. Scribes could have been recruited from volunteers, or from local firefighters, the OPP, or municipal employees.

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The creation of a contemporaneous record maintained in the command tent is also important to inform a new team at the beginning of its operational period of what has been done and what remains to be done in relation to any aspect of the incident action plan. The form of that record is not of primary importance. It could be written on the side of a truck or on sheets of paper, so long as it is clear for all to see. In fairness, the photographic evidence does show a whiteboard in the command tent enumerating tasks accomplished and tasks to be completed *for a specific shift*. It did not, however, extend beyond that time period, and it certainly did not outline the entire incident action plan.

## Communications weaknesses

It is probably trite to state that an effective communications strategy is critical to any emergency response incident. Never have the means to communicate effectively been so sophisticated, efficient, easily accessible, and relatively inexpensive as they are today. But there is a world of difference between ready access to the tools of communication and the effective implementation of a communications strategy during a deployment. Responders need, above all, to communicate with one another in order to understand the mission's objectives and to know what their specific assigned tasks are. Commanders are in constant need of information about the progress of all aspects of the evolution of the rescue. The left hand needs to know what the right is doing. Local officials, the media, victims' families, and the general public must be kept informed.

From a communications perspective, a number of aspects of the Elliot Lake deployment fell far short of ideal.

## Among responders

I have heard no evidence that the responders to the Elliot Lake tragedy lacked for sophisticated hardware and software systems. But effective communication need not depend exclusively on complex equipment. The

The responding organizations – the OPP, the Elliot Lake Fire Department, UCRT, HUSAR/TF3, Emergency Medical Services – all operated on different radio frequencies. Short of exchanging portable telephones, they had no way of communicating directly one with the other to exchange information.

responding organizations – the OPP, the Elliot Lake Fire Department, UCRT, HUSAR/TF3, Emergency Medical Services – all operated on different radio frequencies. Short of exchanging portable telephones, they had no way of communicating directly one with the other to exchange information. When the OPP helicopter's downwash threatened the precarious stability of the hot zone, persons on the debris pile could not wave it off directly.

The incident commander had no means of rapid direct communications with responding organizations (apart from firefighters) except by speaking to them in person. One of the stated purposes of the Incident Management System is to allow responders from different organizations to work together effectively. This objective will continue to be hindered until the province addresses the inherent difficulties in communication among responders arising from a lack of common radio frequencies.

## With victims' families

Communications with the victims' families were inadequate and inconsiderate, particularly during the earlier stages of the deployment. The families were not segregated, but essentially treated no differently from members of the public at the Collins Hall. They received news about their loved ones at the same time as the general public; indeed, they were treated rather shabbily by Insp. Jollymore, who told them he "was doing them a favour"<sup>1</sup> and being polite by attending at the Collins Hall to give them information. The manner in which family members were advised of the decision to call off the rescue was insensitive. Only later in the process were family members provided with separate commercial offices and given constant OPP liaison assistance.

## With the general public and the media

Lack of a well-structured communications strategy aimed at the general public led to a real apprehension of civil unrest in Elliot Lake and required that responding units take steps to ensure their own safety as well as that of their equipment. Directions had to be given to create a security cordon around the Algo Mall to prevent the possible unauthorized entry by members of the public.

Frequent, well-publicized, and regular informational sessions about work being done in the hot zone did not occur. Instead of information being channelled through a single source, information was provided to the press and the public, at various times, by the mayor, Staff Insp. Neadles, and even Mr. Hefkey. Consequently, members of the public, and even some first responders, were getting information (and misinformation) through the media.

## Calling off the rescue done too hastily and with inadequate consultation or consideration of other options

At 12:05 p.m. on June 25, Staff Insp. Neadles was publicly reporting that someone was still alive under the rubble, but that rescuers had to be removed from the pile and crane operations had to stop because of the danger of a further collapse. He also indicated that they were still working and moving forward. But within two hours, everyone was ordered out of the building. Although that decision cannot be questioned because it

was based on the best professional advice available at the time, further consultation should have taken place to determine whether other possible solutions might be available. By approximately 2 p.m., the decision was made that no options remained but to declare the operation a recovery and no longer a rescue. That decision was announced at the 3 p.m. Community Control Group meeting, when Staff Insp. Neadles stated that the operation was being turned back to the Elliot Lake Fire Department. No effort seems to have been made to explore other options despite the fact that Mr. Cranford had considered means to shore the beam under the escalator and had informed Capt. Comella accordingly. Mr. Jeffreys appears not to have been consulted about options. Mr. Selvers believed that crane operations were still possible, but he was not consulted at all. Staff Insp. Neadles had no experience with steel shoring and did not explore this method further. Ontario Mine Rescue was not even considered.

That this decision was made and announced without Chief Officer's explicit concurrence shows the extent to which the command structure had become degraded.

What is particularly difficult to understand is why it was deemed urgent or necessary to announce a definitive end to the rescue. It would have been comparatively much easier simply to say that rescuers were taking a pause in their efforts because of safety concerns and pulling back temporarily while other options were being explored.

## Ontario Mine Rescue not utilized

Ontario Mine Rescue (OMR) has been in existence since 1929. The depth of its experience and expertise is indisputable. Although some aspects of its training, skills, and capabilities would not have assisted the Elliot Lake operation, others were clearly and directly applicable. I refer specifically to shoring, high-angle rescue and rappelling, use of and access to thermal imaging equipment, cribbing and stabilization, and other areas. Its qualifications closely parallel those of HUSAR/TF3 and UCRT.

Qualified personnel and leadership were available from Sudbury and could have been on site in Elliot Lake within two-and-a-half hours. On learning of the collapse, Candys Ballanger-Michaud, the president and chief executive officer of Ontario Mine Rescue, placed a call to the Elliot Lake mayor's office to offer its services, but he was not reachable. A call was made to the Ministry of Labour's Operations Division. The OMR offer went unheeded. Mr. Hefkey advised Staff Insp. Neadles to consider "mining type resources." When specifically asked to consider OMR, Staff Insp. Neadles was resolutely against the idea because he believed that it did not have the expertise and training in a structural collapse. How he came to hold that belief is difficult to discern from his answers to Commission counsel except that it was a conclusion he and Cmdr. McCallion came to in discussions. It is clear to me that he had no idea about OMR's capabilities and expertise.

On the afternoon of June 25, HUSAR/TF3 had no Plan B. Despite that, no effort was made to contact OMR. Failure to even consider using its services, either from the outset or when HUSAR/TF3 had run out of ideas, will always lead to the unanswered question: Had OMR's expertise been sought at the outset and its capabilities utilized, would the result of the rescue attempt have been different?

**Failure to even consider using OMR's services, either from the outset or when HUSAR/TF3 had run out of ideas, will always lead to the unanswered question: Had OMR's expertise been sought at the outset and its capabilities utilized, would the result of the rescue attempt have been different?**



## Confusion about the role and actions of the Ministry of Labour

Throughout the rescue operations, there was a widespread belief, both in Elliot Lake and even in Toronto, that a Ministry of Labour order had prevented entry onto the collapse site. Later, many were also clearly of the belief that evacuation of the Mall stemmed from MOL orders. Staff Insp. Needles went so far as to state publicly that “our authority did end when the building was deemed unsafe by the ministry and other structural engineers.”<sup>2</sup> Although the ministry did, ultimately, have that authority, the ministry clearly never exercised it or threatened to exercise it. There was widespread confusion about the MOL’s powers and near-universal misinformation about the existence of MOL orders stopping the rescue effort. The site of a rescue is clearly a workplace, and the *Occupational Health and Safety Act* applies, even though MOL engineers and inspectors believed that the exercise of discretion was warranted and considerable deference was to be accorded to the rescuers’ expertise.

MOL engineers and inspectors provided useful advice throughout and acted most responsibly. They never interfered with the progress of the rescue efforts.

## After the operation

### Poor debriefing; delayed MCSCS after-action report

A good debrief should not be considered to be an exercise in negativity and criticism. Rather, it is an opportunity to foster the free flow of information between participants to provide as contemporaneous a record as possible of observations, experiences, and emotions – recounting decisions made and results obtained – with a view to the eventual analysis of that information and its potential applicability to future events.

**In my opinion, the value of a good debriefing lies in its relative immediacy after the relevant event. Memories are vivid and fresh, and revisionism has not had an opportunity to creep in.**

In my opinion, the value of a good debriefing lies in its relative immediacy after the relevant event. Memories are vivid and fresh, and revisionism has not had an opportunity to creep in. Next to the maintenance of a proper record (via note-taking and scribes), it constitutes the best method for the transmittal of information vital to ensuring preparedness for future incidents.

After the events of June 23–27, important opportunities for meaningful debriefing were missed. I am skeptical of the reasons advanced for the failure to debrief, particularly because the relevant policies and literature as well as the experience of the responders consistently emphasized the importance of the process. Fatigue or lack of funds were advanced as convenient excuses, but I am much more inclined to the belief that fear of criticism and reproach, as well as a

desire to mask the existence of intra-organizational discords, were the principal agents motivating their absence. Indeed, some witnesses admitted as much.

The City of Elliot Lake, the Elliot Lake Fire Department, the Ministry of Labour, and HUSAR/TF3 all neglected to engage in this critical process. The Ministry of Community Safety and Correctional Services produced a consolidated after-action report dated September 27, 2013, more than *one year* after the events. The OPP Field Support Bureau also prepared an after-action report. The Commission’s copy is undated.

The Office of the Fire Marshal prepared an illuminating and carefully reasoned after-action report on November 14, 2012, that recommended, *inter alia*, the creation of light and medium search and rescue teams spread throughout the province for early reconnaissance and on-ground expertise ahead of the arrival of advance USAR capabilities; communications support; the mandatory adoption of IMS; coordinated training; and the streamlining of governance models in relation to complex emergencies.

## **The Coroners Act**

After rescue efforts were stopped, a problem arose relating to the safe and dignified removal of the victims' remains. This situation led to a recognition that there was no statutory authority to make a building safe (by demolition, for example) in order to remove a body. Fortunately, the matter was quickly resolved by obtaining the owner's consent to a controlled demolition to make entry safe.

## **The decision to use the Priestly equipment**

Sgt. Glavin's knowledge about the existence and capabilities of Priestly Demolition was fortuitous and extremely useful when he spoke to Staff Insp. Neadles about it. And yet, Staff Insp. Neadles already knew of its capabilities and ability to dismantle a building with precision. He had worked with the company before. Priestly Demolition is well known in the Toronto area and has a depth of experience. I would have expected it to figure prominently in HUSAR/TF3's inventory of potential external resources. Clearly, it did not.

Armed with his refreshed knowledge, Staff Insp. Neadles could inform the Premier's Office and various other authorities that there were means whereby the rescue operation could be resumed without endangering rescue personnel.

## **The assistance of the premier**

The premier's evident concern, leadership, and insistent encouragement to explore this last possibility of rescue gave renewed hope to the victims' families and to the community. He was instrumental in developing the missing Plan B. He was supported in his genuine determination to help Elliot Lake and its citizens by members of his staff, as well as the other provincial authorities who acted quickly to give effect to his commitment.

## **General observations**

It is beyond this Commission's mandate and capabilities to inquire into, comment, and make recommendations about the overall framework of Ontario's emergency response system, except to the extent that this framework had an impact on the search and rescue effort at Elliot Lake. It is a framework that evolved gradually and organically, with some renewed impetus after the events of September 11, 2001.

Despite that limitation, I venture the opinion that the system, particularly in the area of urban search and rescue, is in need of rationalization, organization, and integration. Although I recognize that emergency response is, philosophically, a "ground-up" system, overall control at the provincial level is rendered difficult by the compartmentalization of a great diversity of resources. Local ownership and control over those resources means that they become more widely available only after local needs are met. HUSAR, an amalgam of the City of Toronto's many departments (fire, police, water, and others), is designed to serve Toronto first and its services are shared through the instrumentality of MOUs, not legislation. Similarly, UCRT belongs exclusively to the OPP. Ontario Mine Rescue operates entirely independently. Some cities have self-contained light and medium USAR response units completely uninvolved in anything but the loosest form of coordinated structure, such as mutual aid agreements with adjoining municipalities.

In the area of urban search and rescue, Ontario possesses a number of "silos" or "towers" that co-operate to some limited extent, but only at the whim and goodwill of individual municipalities or organizations. By their nature, they are anchored to their parent municipalities or organizations and jealous of their autonomy, their

expertise, and their independence. This insular and protective attitude does not foster efficiency. It impedes identifying, developing, and disseminating evidence-informed practices or the brokering and encouragement of effective methodology.

In the Elliot Lake deployment, there was occasional discord and tension between two specialist organizations that should, optimally, have worked together harmoniously and in a synchronized manner; they did not always do so, despite many commonalities in training and experience. That friction was more evident at the senior levels. The “troops” worked together well and with mutual respect.

In addition, it is worthwhile to reflect on the sheer size of this province and the difficulties created by the huge distances between southern Ontario’s relatively sophisticated network of emergency response organizations and the province’s northern communities. An emergency like the one in Elliot Lake occurring in Timmins, Kapuskasing, or Hearst, for example, would present enormous logistical challenges, particularly during the winter season. Similar considerations apply to northwestern Ontario. The existence of USAR hubs in those regions is markedly absent, although Thunder Bay might more easily become one, should the provincial government consider entering into an MOU to that effect with the municipality. Thunder Bay Fire Rescue has developed capabilities and experience related to industrial accidents, high- and low-angle rescue, and confined-space emergencies.

## Conclusion

The Elliot Lake rescue effort will not be remembered in the annals of the discipline of emergency management and response as a model to be emulated. But it will be of considerable utility going forward if it is considered a learning experience. True learning occurs through the honest recognition of error and the sincere determination to avoid repetition. I was privileged, through the Commission process, to have met or learned of men and women of great sincerity, courage, and strength of character who forthrightly admitted error and expressed their resolve to learn from that recognition. They are truly engaged on the road to excellence.



## Notes

- <sup>1</sup> Exhibit 6402, p. 2; Latulippe testimony, August 7, 2013, pp. 19885–6; Kerr testimony, September 25, 2013, pp. 27328–30.
- <sup>2</sup> Exhibit 9341, p. 2.



# Recommendations

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## Introduction

In this chapter, I once again look ahead with recommendations for changes to policies, procedures, and practices supported by the lessons gleaned from the Algo Mall emergency response. I refer the reader to the general comments I made in my introduction to the Recommendations for Part One of this Report. They apply equally to Part Two. In particular, in making the recommendations that follow, I reiterate that I favour a conservative and pragmatic approach:

- Solutions must be cost effective.
- Solutions must be practical.
- Implementation must be reasonably achievable.
- Implementation must be likely to attract consensus, support, and approbation from as broad a cross-section of society as possible.

The nature of the Part Two recommendations, however, is to some considerable extent qualitatively different from those in Part One. Many of my proposals in this part require policy and attitudinal change more than they do legislative or regulatory amendment. Many require collaboration with entities that are, strictly speaking and in the existing legislative context, independent of government.

More specifically, some of my recommendations are meant to provide more rapid provincial advisory assistance and support to smaller municipalities that do not have the financial means to afford the sophisticated systems that large upper-tier municipalities enjoy when faced with a local emergency. Others deal with the underlying philosophy of the Incident Management System (IMS) in existence in the province. Although many of these recommendations have as their genesis the evidence heard during the Commission's hearings, most received strong support from the experts during the policy roundtable sessions. The response of the roundtable participants, therefore, bolstered my confidence in their advisability and viability.

Many recommendations are aimed at making the emergency assistance process more efficient through more rapid response times, assurance of adequate response personnel, training in different rescue techniques, enhanced communications and record-keeping, and adherence to and understanding of the IMS through enhanced training. The recommendations also suggest looking at different approaches or models of emergency response in Ontario and elsewhere and improved synchronicity and co-operation among emergency response organizations.

They also recommend a more sensitive and caring approach to victims and their families.

The Commission recognizes that funding has always been, and will always be, a valid concern to governments at all levels. However, the need for public security and safety requires the reinstatement of federal funding for HUSAR/TF3,\* in particular, considering its trans-border responsibilities. It seems unfair that provincial and municipal taxpayers should bear the entire burden of this valuable national asset.

Finally, these recommendations speak to improvements in the Commission process itself and urge a public accounting on the implementation of these recommendations.

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\* Heavy Urban Search and Rescue Task Force 3.

## Recommendations

### Provincial organizations and capabilities

There are nine municipal chemical, biological, radiological, nuclear, and explosive (CBRNE) teams located throughout the province with which the Ontario government has memoranda of understanding (MOUs). This arrangement means that they are deployable by the province.



#### Recommendation 2.1

**The capacity to respond to structural collapse emergencies should be increased in Ontario.**

**Rationale:** The vast majority of municipalities have limited or no capacity to provide an urban search and rescue in response to a structural collapse and therefore rely on resources available from the province.

In my opinion, the capacity of provincial urban search and rescue (USAR) resources to deploy to structural collapse incidents in a timely and effective manner is inadequate to serve a province the size of Ontario. Kenora, Thunder Bay, and Hearst are, respectively, 1,900, 1,400, and 900 kilometres by road from Toronto (in round numbers). Elliot Lake, by comparison, is 540 kilometres away. Huge areas in the northern part of the province are accessible only by air. The only assets available for deployment and assistance to municipalities are HUSAR/TF3 and the OPP UCRT,\* both located in the Greater Toronto Area. Developing teams of similar expertise and capability that would be available to distant municipalities is a daunting task requiring expensive solutions at a time when, according to roundtable participants, budgets are shrinking.

An analysis of the province's existing USAR overall capability transcends this Commission's mandate, but common sense alone indicates that more USAR assets, with a wider distribution, are desirable to ensure adequate coverage. In any rescue operation, time is always of the essence. As I say, comprehensive solutions are beyond this Commission's capabilities, but certain avenues ought to be explored in crafting at least a partial solution to this complex issue. Those avenues are the subjects of the following recommendations.

The bottom-up approach to emergency management places the responsibility on the municipality before the province. The municipality decides the level of emergency service it will provide, including whether to have USAR capability. However, budgetary considerations determine the level of service. Both to start and to maintain USAR capabilities is an expensive undertaking for any jurisdiction. Fortunately, to date at least, there have been few incidents requiring the attention of the provincial USAR teams and equipment.

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\* The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team.



The fact that a USAR team is very expensive, coupled with the reality that it may be deployed only rarely, if at all, makes its funding unattractive for a municipality. To increase the number of USAR teams, whether medium or heavy, will require robust funding support from the provincial government. The province has recognized the need to re-examine the deployment model and has indicated in its Elliot Lake Consolidated After-Action Report its intention to do that.

**Implementation:** The province should immediately begin its re-examination of the deployment model. This work should be done in collaboration with municipalities and other interested parties.



## Recommendation 2.2

**The provincial government and others should explore possible collaboration with Ontario Mine Rescue as a partial solution to ensure adequate province-wide capability to respond to structural collapses.**

**Rationale:** Ontario Mine Rescue appears to be an untapped resource that could potentially make a significant contribution to the USAR inventory.

Ontario Mine Rescue has trained and equipped thousands of volunteers who have fought fires, rescued injured personnel, and responded to a wide array of incidents in the province over the past eight decades. It staffs, equips, and maintains a network of mine rescue stations across the province, mainly, though not exclusively, in the north. Currently there are approximately 875 trained volunteers, all of whom are mine employees. Its network covers an area of Ontario that is the most distant from Toronto and therefore the most difficult to reach rapidly by HUSAR/TF3 and UCRT.

A mine collapse is not the same thing as a building collapse. However, both have many commonalities. A rescue at either can involve similar tasks, such as shoring and lifting. Ontario Mine Rescue's province-wide network is fully operational at this time. It presents a rich opportunity for collaboration that should be explored. Alex Gryska, director of Ontario Mine Rescue, indicated a willingness to participate in such a discussion.

**Implementation:** The province should engage in discussions with Ontario Mine Rescue to collaborate on possible joint initiatives in respect of urban search and rescue.

I note that these discussions have already taken place with HUSAR/TF3. In an article posted online on March 24, 2014, in *Northern Ontario Business*,<sup>1</sup> Mr. Gryska spoke of a possible collaboration with HUSAR/TF3. The province should become an integral part of these discussions. According to the current bottom-up model, it would be the province that would likely deploy Ontario Mine Rescue. With its presence predominately in the northern part of the province, it potentially could play a leading role in a USAR response. In short, it would be ideal if Ontario Mine Rescue resources could be directly and independently deployable by the province.



### **Recommendation 2.3**

**The province should initiate discussions to bring the medium urban search and rescue (USAR) teams that currently exist in Ottawa and Thunder Bay into the provincial inventory.**

**Rationale:** The teams in Ottawa and Thunder Bay appear to be strategically situated and potentially ready-to-go additions.

The cities of Ottawa and Thunder Bay each have a medium USAR team, but the province does not have an MOU with either of them, and consequently they are not deployable by the province at this time. Dan Hefkey, commissioner for community safety, informed the Inquiry that the government was taking steps to change that. However, the teams were still not deployable by the province when the roundtables were conducted in December 2013.

Chief John Hay of Thunder Bay Fire Rescue participated in the policy roundtables. Thunder Bay has one of the provincially deployable CBRNE teams. He felt that the CBRNE model of regionally dispersed teams that are deployable by the province worked fairly well and thought it should be studied in the context of USAR. This model appears to provide an expeditious way for the province to expand its capabilities. It also offers a more cost-effective alternative plan to funding a team from scratch. The teams' locations extend the reach of the province's ability to provide timely assistance.

**Implementation:** The provincial government should negotiate a memorandum of understanding with both Ottawa and Thunder Bay (which both have urban search and rescue teams) that would, among other things, allow the province to deploy those teams on a cost-recovery basis.



### **Recommendation 2.4**

**On request, the province should make incident support teams available to incident commanders.**

**Rationale:** An incident commander may become overwhelmed by an event and require management support.

In the bottom-up approach to emergency management, overall command of the event always resides with the local incident commander. Even when considerable provincial resources are brought in, they are there to support the incident commander. However, an emergency response can be complex and of long duration. It is not realistic to expect that a local incident commander will necessarily have at his or her disposal a management

team capable of dealing with a complex incident such as a structural collapse. In those circumstances, the incident commander should be able to request assistance with the management of the emergency. The incident commander should be able to reach out and request the assistance of, for example, a trained logistics person to act as his or her logistics section chief. The person sent would be in charge of logistics but would report to, and be under the command of, the incident commander.

In a similar manner, I see no reason in principle that the incident commander who feels overwhelmed by the size of the event or its duration could not get some help with the management of the entire incident. He or she would still remain the incident commander; the third party brought in to assist would, in effect, serve as the deputy. The deputy would offer suggestions and advice, but it is the incident commander who would have the final word. In certain instances, the deputy could, in fact, assume temporary command to allow the incident commander to get some rest. This expanded role found considerable support at the policy roundtables.

**Implementation: Create a pool of persons deployable by the province capable of exercising the five functions of the Incident Management System (IMS).**

These individuals could have expertise in some or all of the IMS functions so long as they are properly deployed (e.g., a planning person should not be sent to do the logistics job). The composition of the pool of these resources could be from municipalities and not necessarily exclusively from the province. Larger municipalities, such as Toronto, have dedicated personnel already able to perform those functions for the city.

Knowing how much training might be required so that a logistics person could perform that function at a structural collapse is beyond my expertise. Another possibility would be for the province to create a pool of teams, with each team experienced in the performance of all IMS functions, rather than a pool of individuals. The participants at the roundtables thought the team approach would be a more effective solution.



### **Recommendation 2.5**

**The province should examine the model of a volunteer-based emergency response used by the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW) to determine if it could have any application in Ontario.**

**Rationale: There may be significant cost savings and other advantages in using a volunteer model, if feasible.**

Eva Cohen, the liaison officer for Canada for the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW), participated in the roundtable. She explained that in Germany, 99 percent of emergency responders are unpaid volunteers from the local community. The volunteers come from all walks of life, not just from the ranks of police, fire, and emergency medical services. The German federal government's role is to fund, equip, and mentor a unified, nationwide structure that guarantees uniform professional standards. The system has been in operation for more than 60 years. The fact that the volunteers are unpaid certainly has its attraction. Ms. Cohen stated that she is working with the City of Ottawa and the County of Renfrew in a pilot project to set up a volunteer emergency response team similar to the THW model.



**Implementation:** In the short term, the province should monitor the pilot projects currently under way. If they prove meritorious, the province should consider adopting all or some of their elements in the province's emergency response inventory.



### Recommendation 2.6

**Statutory authority should give jurisdiction to a coroner to authorize entry to a building, by any safe means including demolition, for the purpose of retrieving a body.**

**Rationale:** At present, it appears that no provincial or municipal agency has such authority. This situation is unacceptable.

After Staff Insp. William Neadles announced that the rescue was over and the response had become a recovery, several officials – including Dr. Craig Muir, the regional coroner; Roger Jeffreys, provincial engineer, and others from the Ministry of Labour; Fire Chief Paul Officer; Robert deBortoli from the City of Elliot Lake; and two OPP officers – had a discussion about how to safely recover the bodies that were still in the Mall. The consensus was that there was no such authority, particularly if recovery involves steps going beyond mere entry.

I agree. The only statute which appears to come close to the issue is the *Coroners Act*. It provides:

16.(1) A coroner may,

(a) examine or take possession of any dead body, or both; and

(b) enter and inspect any place where a dead body is ...

...

(3) A coroner may authorize a legally qualified medical practitioner or a police officer to exercise all or any of the coroner's powers under subsection (1).<sup>2</sup>

...

16.1(1) The Chief Coroner may appoint any person, in accordance with the regulations, to exercise the investigative powers and duties of a coroner.<sup>3</sup>

These subsections do not authorize a coroner, or anyone else, to break down walls or destroy property in order to make it safe to retrieve a dead body. Some public authority should be able to do that. It is unacceptable that a building in which deceased persons are located and from which they cannot be safely extricated could be turned over to the owner to be dealt with as he or she sees fit, as was proposed on June 25. Fortunately, in this instance, the owner consented in writing to demolition in order to access and remove the victims.

**Implementation:** Enact an amendment to the *Coroners Act* to authorize such actions.

The *Coroners Act* permits entry on private property to take possession of a dead body. The Act should be amended to authorize the enabling of safe entry by appropriate means.



## Incident Management System / chain of command

Ontario has developed, with input from a number of first-responder units and services across the province, a detailed Incident Management System (IMS) doctrine. It presents a standardized organizational structure, functions, processes, and terminology. It is intended to be used, when and if it is ultimately adopted, in all incidents requiring an emergency response. It is, however, optional in two key aspects.

First, although its adoption by emergency management organizations is desirable, it is not mandatory and, indeed, many have not adopted the IMS. For example, most fire services follow a similar, but not identical, system called the Incident Command System. It is therefore possible that a number of organizations responding to an emergency may be using different response systems.

Second, because it is intended to apply to all emergencies, from a single-car accident to a massive earthquake or explosion, it is “scalable,” meaning that those who use it can pick and choose which elements of its structure, functions, and processes will be used.

The IMS identifies five key management functions: command, operations, planning, logistics, and finance / administration. It suggests that there be a section chief for each of the last four functions, all reporting to the incident commander. It does not, however, require that one person be identified as being responsible and accountable for each of these crucial functions. In Elliot Lake, there was no planning chief, because the only person trained for that function was not available. Capt. Tony Comella testified that planning was “a hat [I] wore from time to time.” He also testified that he shared the workload of the planning chief position with Capt. Martin McRae.<sup>4</sup> Capt. McRae testified that he was never the planning chief, and that he did not believe that planning was done by one person.<sup>5</sup> Staff Insp. Neadles testified that there was no one assigned to that role, and that it was undertaken by “a couple of different people at different times.” When asked whether one person should be assigned to that role, he responded by saying:

It doesn't have to be that way. The way IMS is structured, it can be – it can be scalable, movable, compartmentalized. It can be people wearing one hat. It can be – it can be people wearing three hats if that is what it is.<sup>6</sup>

Similarly, the IMS “requires” that an incident action plan be developed. Because all aspects of IMS are optional, however, none is truly required. It appears that no incident action plan was developed in Elliot Lake. Although plans were discussed, they can be described only as vaguely fluid and ill defined. No proximate or ultimate objectives were defined. No timelines were specified. No plans were agreed on by or communicated to all important players until Ryan Priestly, president of Priestly Demolition, wrote down his plan on June 26 and had it signed by provincial engineer Mr. Jeffreys and Staff Insp. Neadles.

The lack of a properly identified planning function may have contributed to the failure of Staff Insp. Neadles to learn, before the rescue operation was terminated on June 25, that James Cranford, engineer with HUSAR/TF3, had developed a possible plan to shore the beam supporting the escalator in a way that could have prevented both vertical and horizontal movement. Mr. Cranford thought that he reported to Capt. Comella, and Capt. Comella did not ask him for the results of his final calculations. If there was an individual responsible for planning, Mr. Cranford would have reported to him or her.

The decision to use a crane to remove the slabs of concrete on the rubble pile appears to have developed almost organically. Its presence on site was not the result of an articulated need that formed part of an articulated plan. Although Cst. Ryan Cox concluded in the very early stages that a crane would be essential, it was not ordered until about 11:15 p.m. on June 23. Staff Insp. Neadles was asked about an update email he sent on June 24 at 1 p.m. which stated that they were setting up “a large crane to assist with some large debris removal.” He gave the following evidence about the decision to use it:

Q. And I gather that there had been a decision made to commence some crane operations?

A. Yes.

...

Q. Mr. Comella gave evidence that he was unaware of what the crane was going to be used for except intuitively. My question to you is who decided that the crane operations were going to commence? Because obviously he didn't.

A. Obviously, that falls back to me, and I am not recalling who I spoke to to authorize the use of the crane. Obviously, I did not speak to Sgt. [Jamie] Gillespie, so I'm sort of lost at who and what that purpose was for other than it was setting up. So I knew it had been ordered by Sergeant Gillespie's team to come and I'm going to say that it was starting to put itself into position and to start working.<sup>7</sup>

Capt. Comella, who was seen to be the operations / planning chief from time to time, testified that, when the update was sent by Staff Insp. Neadles, he was not aware of what the crane was going to be used for and did not know what the primary objective of the responders was. The only thing he understood at that time was the shoring operation working toward the pile.<sup>8</sup>

The IMS doctrine is also, on first review, quite complex. The doctrine book is 123 pages long, with 11 chapters. It includes complex charts intended to assist in understanding the doctrine. Many of its features are valuable to those involved in the management of emergency responses. It is unrealistic, however, to expect that the doctrine and all its complexities will be understood by the men and women who are on the ground making the myriad of decisions required in an emergency response.

As an illustration, the IMS allows for command, in rare instances, to be shared among individuals representing different organizations involved in the response. This practice is called the “unified command model.” It has been referred to by some as “management by committee.” A number of the responders who testified before me, however, had different understandings about the meaning of unified command. Some thought that it referred to a number of different responding organizations having representatives at the decision table, but the final decision being made by one person. Furthermore, there was not agreement among the witnesses about whether unified command was the model used in the Elliot Lake response.

It is apparent to me that there was general confusion in Elliot Lake about who was in charge. Capt. Comella testified that at times he was the safety officer, at times the incident commander, and at times the operations section chief. Although Fire Chief Paul Officer was the incident commander, not all understood or respected that. He, himself, did not grasp its significance until after the Community Control Group (CCG) meeting at 3 p.m. on June 25 when Staff Insp. Neadles declared that the response had become a recovery – a decision which was not his to make. A further example of the lack of understanding of who fulfilled the role of incident commander occurred on June 23, shortly after the collapse. An OPP helicopter was called in to assess the scene. This decision was made without consulting or advising Chief Officer, putting the rescuers in the hot zone at risk from the downdraft and its effect on the beam and the “widow makers” overhanging the rubble pile.





### Recommendation 2.7

**Whenever a municipal or provincial emergency is declared, its management should contain the following mandatory features, each of which is reduced to writing:**

- **a clear chain of command;**
- **defined responsibility and accountability for all in the chain of command;**
- **a clear and consistent line of communication for all responders;**
- **a plan of action determined by the individual in charge after consultation; and**
- **an early and comprehensive briefing of all team members before the plan is carried out.**

#### **Rationale: Optimizing safety and success of the response requires such guidelines.**

In my view, the essential elements of managing a complex emergency response, like any other complex task to be carried out by a large number of persons, do not need to be complicated. None of them is overly time consuming. What is required is:

- a clear chain of command. One person must be responsible and accountable for the decisions made, and the roles of each person in the chain must be clearly understood by all;
- a thorough and well-articulated plan, determined after appropriate consultation;
- clear and unambiguous communication of the plan to those who will execute it; and
- a written record documenting each of those prerequisites.

A perfect response – what the Incident Management System strives to achieve – undoubtedly requires more. But a response that works must include at least these features. They should form the essential and mandatory nucleus of the response while more peripheral aspects of the application of IMS evolve, are improved on, and ultimately are incorporated. As Voltaire wrote, the best is the enemy of the good (not a literal but an accepted translation of “*Le mieux est l’ennemi du bien*”). The utility of this nucleus of mandatory features is illustrated by the experience of Ontario Mine Rescue developed over many years of responding to emergencies in underground mines. Although serious and fraught with risk, these emergencies are often not as complex as those faced by the responders in Elliot Lake, since they may not involve more than one responding organization. As Mr. Gryska testified, however, Ontario Mine Rescue has learned that each of these elements is critical to success. One person has to be accountable for decisions. It is no answer to say that preparing a plan is too time-consuming – success requires that the team understand the dangers, risks, and hazards to which it will be exposed. A proper briefing is essential – it ensures clarity and understanding about the mission, where the team will go, and what it will do. Lines of communication that are both clear and easily understood will ensure that necessary information gets where it needs to go. Requiring that each of these things be written down ensures that due consideration is given to the decisions being made (because the act of writing intuitively forces the writer to confirm that what is being written is correct), and that there is no ambiguity about what was decided.

Witnesses at the policy roundtables who spoke to the point were unanimous in expressing the value of a written incident action plan (although not about whether a written plan should be required in all responses). The IMS states that an incident action plan should contain:

1. a statement of objectives, expressing in a measurable manner what is to be achieved;
2. clear strategic direction;
3. the tactics to be employed to achieve each overarching incident objective;
4. a list of resources that are assigned;
5. the organizational structure / chart; and
6. safety guidelines or requirements.<sup>9</sup>

There was no plan, written or oral, that met these standards in Elliot Lake before the Priestly plan on June 26.

The statutory requirements for the declaration of an emergency are useful indicators of when each of the minimum organizational requirements I have recommended, including a written plan, ought to be required. The *Emergency Management and Civil Protection Act* provides for either the head of council (the reeve or mayor) of a municipality or the province (through the premier or the lieutenant governor in council) to declare an emergency.

An emergency is defined, for the purpose of a declaration by the head of a municipal council, as:

A situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.<sup>10</sup>

An order declaring that an emergency exists throughout Ontario, or any part of it, may be made by the premier or the lieutenant governor in council if the following criteria are satisfied:

1. There is an emergency that requires immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons or substantial damage to property.
2. One of the following circumstances exists:
  - i. The resources normally available to a ministry of the Government of Ontario or an agency, board or commission or other branch of the government, including existing legislation, cannot be relied upon without the risk of serious delay.
  - ii. The resources referred to in subparagraph i may be insufficiently effective to address the emergency.
  - iii. It is not possible, without the risk of serious delay, to ascertain whether the resources referred to in subparagraph i can be relied upon.<sup>11</sup>

A declaration of emergency will clearly be made only where the incident is significant enough that some thought and planning will be required in order to respond appropriately. I cannot conceive of a situation that is serious enough to justify a declaration of emergency which would not require the minimum elements set out above.

**Implementation: A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act*.**

Subsection 14(1) of the *Emergency Management and Civil Protection Act* gives the province authority to make regulations setting standards for the “formulation and implementation of emergency plans under sections 3 and 6” of that statute. Those sections require each municipality, each cabinet minister presiding over a government ministry, and each provincial agency, board, or commission to formulate an emergency plan governing, among other things, “the procedures under and the manner in which employees of the municipality [or, in the case of a provincially declared emergency, “public servants”] and other persons will respond to the emergency.”<sup>12</sup> The “emergency” referred to in the statute is an emergency so declared by the respective level of government.

A regulation should be enacted requiring that these plans contain the provisions I have recommended. This objective could be achieved by requiring the incident commander to ensure that each of these requirements is met.



### Recommendation 2.8

**There should be only one person in overall charge of a response; a “unified command” structure should be avoided.**

**Rationale:** One final decision-maker is essential to avoid conflicts or impasses caused by failure to reach a consensus. The concept of a unified command structure intrinsically contradicts the unity of command doctrine because it fails to ensure that decisions are made by someone who is ultimately responsible and accountable.

The Incident Management System doctrine states:

IMS operates on a defined and specific command and control structure that provides an orderly line of command and accountability, and which is based on the function to be performed and the expertise of the incident management staff, rather than rank, organization or jurisdiction. To ensure unity of command, each individual should have one clearly designated supervisor, who may or may not come from the same jurisdiction or service.

Command of an incident may be exercised through a single command process when one response organization has jurisdictional or functional responsibility for the incident, or under a unified command process, where multiple response organizations or jurisdictions have jurisdictional or functional responsibility for the incident. Whether the IMS is operating under a single or unified command structure, unity of command must be maintained.<sup>13</sup>

In my view, these two paragraphs contradict each other. There is neither “one clearly designated supervisor” nor “unity of command” where more than one person has responsibility for the command of the incident.

Deputy Chief Ronald Jenkins of the Toronto Fire Service described unified command as “command by committee.”<sup>14</sup> Mr. Hefkey, one of the architects of the IMS doctrine, gave this evidence:

So under unified command, it is operating on the assumption that we – so, again, while we can have disagreements, we’ve now engaged in a unified command structure because we see the benefits – for the very reasons that you just talked about: I don’t know everything that you know and you don’t know everything that I know, so we are dependent, co-dependent . . . As a result, that’s why you have a unified command. It is rare, but that’s what you have. And it is then – when you enter into that agreement, it’s



not – like, again, as was asked, *there is no supreme arbiter to the things. It is: We are committing; you and I are committing to commanding this incident jointly so that we can come to a mutually acceptable conclusion so that your interests and my priorities are all met*, that we do it. But that's where, again, I want to go back, it's not – again, it's not clean, and it's not to say you're going to have – you're going to have harmony one hundred per cent of the time. There are times where there is disagreement but when you decide that you are going to enter into a unified command arrangement that's what you are doing.

...

Q. ... a course of action between the two leaders of a unified command, assuming it is two, to disagree is not acceptable; correct?

A. No, they can disagree.

Q. Sorry, if the disagreement results in no decision being made?

A. That's unacceptable.

Q. That's unacceptable.

A. Absolutely, correct.

Q. You – in that particular case you would have a dysfunctional unified command?

A. That is correct.<sup>15</sup> [Emphasis added.]

As I have indicated, the “unified command” structure is not well understood by the men and women who have to work with it on a regular basis. This difficulty is, in my view, because they understand that a system which allows for the possibility of clashing or inconsistent decisions is unworkable.

Capt. Comella testified:

Q. [W]hat is the structure of unified command and who is – how do they arrive at decisions or who is the decision-maker?

A. Well, in this situation, with the people that you have listed, there should be a representative of each one of those agencies within the unified command. Each one of those personnel should be appointed as a Commander or Commander's assistant or second or designate, however they want to deal with that. And then information should be coming upstream to them, from their respective agencies, based on their respective tasks at the time. And that will allow for a clear picture to the commanding group as to overall success of the mission and current status of – probably a more clear understanding of current status.

Q. And does the decision-making lie in the group or does the decision-making lie with a single person?

A. I guess that depends on who you ask that question to. I think that the intention of unified command is that the group will review all of the data and collectively make a decision. *I guess the big question is: What happens if there's a tie? Who's the tiebreaker?* In my opinion and it is only my opinion, I think that the Incident Commander would be the tiebreaker at that point in time, the original Incident Commander.<sup>16</sup> [Emphasis added.]

Staff Insp. Needles testified:

Q. And what is the decision-making process in a Unified Command? Is there – is it essentially a decision by consensus or is or is there somebody who ultimately sits on top and says this is what we are going to do?

A. By the definition of unified command, as I understand it, it is both. You are going to try and come up with every decision by consensus, but one individual would have the veto or the last position to take that if in fact the group either couldn't come up with a viable decision-making process or if that individual was not in agreement with. But that last decision should still lie with the individual who is the lead agency.<sup>17</sup>

A final decision-maker is necessary in any organization for reasons other than the necessity of making a decision when a consensus cannot be achieved. Joint decision making may be a convenient refuge to avoid responsibility or a wish to share its burden. Sole responsibility focuses the mind and the conscience. It eliminates the potential for individuals conflicting orders from a variety of supervisors; it emphasizes accountability, discourages freelancing, facilitates the flow of information, makes the coordination of operational efforts more efficient, and enhances operational safety. The chain of command requires that each responder takes orders from only one superior and gives orders only to a specifically identified person or group immediately below him or her. Each individual participating in the operation reports to only one supervisor, and this practice should apply all the way up the chain to a single individual. All successful organizations work this way. Otherwise, "too many cooks will spoil the broth." In my opinion, the unified command model is notionally and practically unworkable. An army cannot have two generals in command; a ship cannot have two captains. The very concept carries within it the seeds for discord, dysfunction, and, at best, inefficiency. It ought to be discarded.

**Implementation:** The Incident Management System should be amended to eliminate the unified command model and require one incident commander at all times.



### Recommendation 2.9

**The incident commander, the senior person in the chain of command, in a municipally declared emergency should be either**

- (a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or**
- (b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.**

**Rationale:** There must be certainty about who is in charge, and local emergencies should be run by either a local authority (unless the local authority does not have the capacity to do so) or the agency best suited to the response.

Chief Officer was the incident commander throughout the Mall collapse response, but, in practice, he did not make the final decisions on key issues. Perhaps the most obvious example was the decision to call off the rescue, which was made by Staff Insp. Neadles, without consulting Chief Officer. The principle of local authorities being in charge of local emergencies is well founded. Those living and working in the community are best positioned to know the unique character and particularities of their region and better attuned to the likely consequences of the emergency. They should not have to divest control simply because they do not have the physical resources to deliver what is required to deal with the emergency.

Having the incident commander as the person in charge of the initial agency that responds also makes sense from the point of certainty. As I have explained, it is essential that someone be in charge at all times, and that his or her identity be clearly known to all. If the person in charge remains the same, the likelihood of confusion is avoided.

Furthermore, the incident commander – the person in charge – does not have to have technical knowledge of all aspects of the response to fulfill the role. He or she should get advice from those with that knowledge. It would have been perfectly appropriate for Chief Officer to seek advice from Staff Insp. Neadles, Sgt. Gillespie, Cmdr. Michael McCallion, Capt. McRae, Capt. Comella, Mr. Cranford, or Mr. Jeffreys. He could have chosen to get advice only from Staff Insp. Neadles, if he was satisfied that it would be sufficient in the circumstances.

Sometimes, however, the local authority recognizes that he or she does not have the ability to make the necessary decisions, or that his or her agency is not best suited to be in charge of the response, given the particular incident at issue. In those circumstances, the authority should be able to delegate the authority to another individual. That delegation should be in writing. This practice ensures that there is no confusion about who is in charge at any particular time.

Some jurisdictions, such as New York City, employ a matrix that identifies, before an event occurs, which agency (or agencies, if a unified command system will be used) will be in command, based on the type of incident being responded to. In New York City, for example, the primary agency in a structural collapse will be the Fire Department.<sup>18</sup> This seems particularly appropriate in larger centres, where more than one service may respond very quickly. It achieves the primary purpose of certainty of who is in charge, and ensures that the person in charge is from an agency best suited to the type of emergency at issue.

**Implementation:** A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act*.

This recommendation should be implemented by the same method as Recommendation 2.7 – by enacting a regulation requiring these provisions in every municipal emergency plan. The plan should state that the incident commander will be either:

- (a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or
- (b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.



### **Recommendation 2.10**

**The province should put in place strategies that will increase the acceptance and actual use of the Incident Management System (IMS) – including simplifying its language and instituting joint training and exercises – so as to be able to make it mandatory in the near future.**

**Rationale:** The IMS has many positive features, but it will not work unless it is used. Making it an accepted and accessible system requires education, consensus, acceptance, and some simplification.

It is not uncommon for police, fire, and EMS personnel to respond to the same incident. Sometimes, as in Elliot Lake, more than one service is involved in a response. IMS provides for, among other things, an organizational structure that facilitates a coordinated joint effort to manage the incident under a specific command.



As the evidence I heard showed, there is often a cultural resistance on the part of first responders, particularly those in uniformed services, to accept orders from someone wearing a different uniform. This attitude results in silos, with each group of responders acting within its own command structure, moving toward the common goal. This situation can lead to unproductive rivalry, friction, and misunderstanding, including the possibility of groups working at cross purposes and, at a minimum, inefficiently. Properly used, IMS eliminates or at least serves to dismantle these silos.

The IMS doctrine is not written in a way that is easily understandable. It should be simplified, with ambiguities removed, so that the men and women who respond to emergencies can clearly understand what they are being asked to do. The Ontario Mine Rescue handbook, in contrast, is much easier to understand. Consideration should be given to producing a similar handbook to be issued to those who will be asked to respond to emergencies. A simple, practical, portable, waterproof handbook, containing the doctrine's essential elements and its practical application in emergency operations, should be developed to be carried in the back pocket of every first responder.

More importantly, there needs to be adequate training to ensure that the system is understood, both in theory and in practice. IMS courses are now offered by the province. They should be provided to integrated audiences of responders from more than one service. This approach would not only allow relationships to develop, but would also allow those being trained to understand the practical issues faced by members from other services.

Training exercises should also be provided on an integrated basis. Few joint exercises have been organized, even by HUSAR/TF3 and UCRT, although those two groups are likely to work together on any urban rescue emergency of a significant size. Acting under the direction of someone from a different service does not come naturally. Mutual understanding and respect, as well as the elimination of inter-service rivalry, are unlikely to occur if team members have engaged at least in joint simulated exercises.

The ultimate goal should be mandatory adoption of the IMS system by all agencies in the province. It is unrealistic to expect the system to work at maximum efficiency otherwise. It is clear, from the discussions at the policy roundtables, that some agencies are not yet ready to adopt the doctrine. A firm date should, however, be set to ensure that this worthy goal does not drift into oblivion. I would suggest five years hence.

**Implementation:** The province should encourage the appropriate agencies to agree on simplifying IMS. The province should initiate and provide training opportunities, and a regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act* requiring that municipal and provincial emergency plans mandate compliance with IMS within a specific period.

The Incident Management System was the product of a committee composed of representatives of a number of organizations. That may be one of the reasons behind its somewhat cumbersome nature. A Permanent IMS Steering Committee has, according to the IMS doctrine, responsibility for making amendments to the doctrine. It should be immediately asked to consider its simplification, as I suggested.

IMS training has, hitherto, been provided by the province. This training should be continued and enhanced, because all residents of Ontario would benefit from an emergency response system that is optimally organized and delivered, and because the only way to ensure that all training is the same is to have only one trainer.

Once the necessary improvements and training have been delivered, no later than five years from now, a regulation should be promulgated under subsection 14(1) of the *Emergency Management and Civil Protection Act* requiring that all emergency plans adopted by municipalities and provincial ministries, boards, and commissions mandate compliance with the IMS.

## Communications

As previously mentioned, the initial response to an emergency in Ontario, including the management of the media response, is local. However, just as the skills of the local first responders can quickly be overwhelmed by the gravity and complexity of an incident, so too can the ability of a municipality and other local resources to manage the media and communications response for larger-scale operations.

I heard evidence during this Inquiry that the mayor and others on the Community Control Group in Elliot Lake were staggered by the media interest in these events. One witness described it as “baptism by fire.”<sup>19</sup> I heard evidence of confusion and indecision about how to communicate the progress of the rescue and the suspected number of casualties to the media, to local Elliot Lakers, and to the public at large.

When the rescue was called off on June 25, management of the communication of that decision to the media and the public was disastrous. The result was uproar and unrest in the local community and the public at large. This situation had a very real effect on the ground for rescue workers and in terms of perimeter security. Ultimately, the OPP did an effective job defusing tension, and the townspeople, understandably incensed at the way the rescue was called off, exhibited commendable restraint.

In Elliot Lake, no one with appropriate experience and training was available to manage (in the non-pejorative sense) the media message. An experienced communicator might well have anticipated the upheaval that could result from a stark announcement that the rescue had ceased shortly after an announcement having been made that signs of life had been detected.



### Recommendation 2.11

**Provincial media and communications expertise should be made available, either as a stand-alone service or as part of incident support teams, to municipalities during declared emergencies or where provincial resources have been used.**

**Rationale:** For large-scale incidents, the local municipality may lack the ability to effectively manage media and public communications. Poor management of media and communications can seriously undermine rescue efforts.

There was widespread support during the policy roundtables for the provision of media and communications support during similar emergency responses in the future. The City of Elliot Lake, for example, recognized the need for the assistance of a media professional.

I heard evidence during the roundtables that provincial media and communications assistance existed and was used during recent emergencies in High River, Alberta, along with contract assistance from a private company. Benjamin Morgan, Calgary’s crisis communications director, told me how he had access to a dynamic group of professionals and communicators, able to “do a great job of keeping the public informed of events.” He pointed out that local leaders having able communications and media assistance during an emergency promotes faith and trust in those leaders. Local leadership is not supplanted, but supported and left better able to do its job.<sup>20</sup>

Similar timely assistance should be available for municipalities in Ontario. Effective communication from first responders and the local Community Control Group is critical to the effective management of an emergency. I agree with the following comment from one of the participants during the roundtables. The words ring all too true when one looks back at the experience in Elliot Lake:

Successful communication could rally the community, provide it much needed info and [be] calming of its public.

But poor communication or no communication could fan emotions, promote rumours and undermine confidence.<sup>21</sup>

**Implementation:** The Ontario government should identify and develop a pool of communication specialists on call and able to provide expert media and communications assistance, either stand-alone or as part of an incident support team. This assistance should be offered immediately to the municipality in all cases where an emergency has been declared or where provincial resources have been used.



## Recommendation 2.12

**The Ontario government should make it mandatory to provide private space and regular updates to family members of victims on the progress of rescue and recovery operations during declared emergencies or where provincial resources have been used.**

**Rationale:** Keeping victims' families informed of the progress of a rescue and the status of their loved ones is a question of respect and dignity, but also good incident management.

In the immediate aftermath of the collapse of the Algo Mall, provision of information to the families of victims was intermittent, inconsistent, and at times insensitive. The Collins Hall was the gathering point in Elliot Lake for both the victims' families and the general public. A room, unsuitably small for the purpose, was made available to the families. Robin Kerr, the representative of Victim Services of Algoma, repeatedly had to press the OPP for details on the progress of the rescue. There were long periods where no information was provided.

The families should have been provided with more frequent and more accurate updates, and should not have had to rely on media reports for information on the status of the rescue and their loved ones. This lack of information led to rumour, speculation, and bad feelings, not only with the families but, through those families, to the general public in the small community of Elliot Lake.

When the rescue was stopped on June 25, the families of Ms. Aylwin and Mrs. Perizzolo were told of the stoppage in public, and not in private. Not all the family members were present when the news was first delivered. The announcement was abrupt and lacked sensitivity and discernment.

It was not until the unrest following the events of June 25 that OPP victim liaison officers were deployed to Elliot Lake to assist the Aylwin and Perizzolo families, and a proper private space segregated from the general public was arranged for the victims' families.



The Elliot Lake Mall Action Committee recommended during the roundtables that a dedicated person or persons be assigned to deal with family members throughout an emergency response, with responsibility to provide frequent, timely, and honest updates on progress, before the release of that information to the public and media. I agree.

**Implementation 1:** A regulation should be enacted under subsection 14(1) of the *Emergency Management and Civil Protection Act* making specific provisions for the needs of family members mandatory in emergency response plans.

As previously noted, the Ontario government has the authority to make regulations setting standards for the “formulation and implementation of emergency plans under sections 3 and 6” of that statute.<sup>22</sup> The government should use that regulatory power to make it mandatory for emergency response plans to contain specific provisions addressing the needs of families of victims. These needs include the provision of private space for family members and, when operationally practicable, priority in receiving information in as respectful a manner as possible.

**Implementation 2:** OPP victim liaison officers should be made available to municipalities, as quickly as possible, for all large-scale rescue operations where there are potential victims.



### Recommendation 2.13

**Training for rescue and recovery operations should stress providing the public with timely and accurate information about casualties and the progress of a rescue operation (subject to legitimate operational requirements).**

**Rationale:** The public’s perception of the Elliot Lake emergency response and its reaction would have been more positive and supportive had it been informed in a timely and accurate way about the number of casualties and the progress of the rescue.

Early on in the rescue, it was clear to rescue workers that one person was most likely deceased and another person trapped and possibly alive. The OPP’s list of missing persons fluctuated, but rescue workers were fairly confident these were the only two individuals trapped. By contrast, the media continued to report larger numbers of people potentially missing or trapped. This misinformation added unnecessarily to public alarm, fears, and concern.

OPP Insp. Percy Jollymore was concerned about releasing a statement that someone was deceased because he did not want to make a mistake. Chief Officer and others from the Community Control Group did not agree with this approach but deferred to the OPP’s greater experience in dealing with coroners. The OPP’s policy appears to be that it cannot confirm a death without an official pronouncement from the coroner or a medical doctor unless there are evident signs, such as decapitation or decomposition. The result was that inaccurate information was provided to the public. For example, at 1 p.m. on June 24, the public was told by press release that there had been no confirmation of loss of life.<sup>23</sup>

The OPP's rigid policy on confirmation of death is not suited to the rescue and recovery milieu. It essentially means deaths cannot be confirmed until rescue operations have ceased and a coroner has been provided access to the bodies. Instead, to the full extent possible, the public should be informed of the truth. In Elliot Lake, from very early on, the truth was that rescue workers believed there to be one victim potentially alive and one that was likely deceased.

Chief Officer told me, when asked about lessons learned, that with hindsight he would have been "much more forceful" in conveying, clearly and precisely, that there was one casualty and one individual they hoped could be saved.<sup>24</sup> By failing to do so, media rumours of more victims persisted and added to the community's sense of confusion, desperation, and helplessness. I agree with Chief Officer's assessment.

In addition, the public was provided with sporadic and incomplete information about how rescue efforts were proceeding and how truly dangerous and complicated the rescue operation was becoming. Clear and timely information would have made the June 25 stoppage appear justified and understandable.

The importance of full, frank, timely, and early disclosure to the public, where at all possible, cannot be overstated. Underestimating the public's ability to deal with complicated and difficult news is unjustified in my view, absent overriding concerns involving such things as public security and valid investigative imperatives. Unrest and mistrust of public officials ensue when secrecy prevails. Even when information needs to be withheld, the public has a right to be told why that information cannot be given out – and it usually understands.

**Implementation:** Future training for all players in the field of rescue and recovery, as well as municipal officials, should stress the importance and means of providing, to the fullest extent possible, accurate and timely information to the public. The Elliot Lake experience would be an illustrative and useful case study.



### **Recommendation 2.14**

**Where multiple agencies are present at a rescue operation, they should have continuous access at the command level to common-frequency radios or communications equipment.**

**Rationale:** The various agencies at a rescue operation need the ability to communicate quickly during emergency response.

The evidence at the Inquiry was that the OPP, UCRT, HUSAR/TF3, and the Elliot Lake Fire Department all operated on different radio frequencies during the rescue and recovery efforts. Sgt. Gillespie was given a HUSAR/TF3 radio, but other members of UCRT were not.

The absence of interoperability of communications equipment led to a certain amount of confusion and inefficiency in the Elliot Lake deployment. For example, I refer to the incident where the OPP helicopter was ordered by Insp. Jollymore to hover above the collapse zone and take pictures. The Elliot Lake Fire Department was forced to evacuate the collapse zone because the helicopter downdraft was causing dangerous movement.

Chief Officer attempted to contact the OPP but did not have a direct radio linkage. If he had, he could have waved off the helicopter more quickly. Different teams were literally not on the same wavelength.

I am aware that inter-agency communications equipment incompatibility has long been the subject of public discussion and debate in this province and elsewhere. It is clearly beyond this Commission's competence to suggest practical solutions to a problem that has hitherto eluded experts. Nevertheless, in an era where technological innovations in the field of electronic communications have developed at prodigious rates of speed, I have difficulty understanding why interoperability strategies have not been crafted to attenuate or eliminate the problems.

Quite obviously, not all responders need to hear all the electronic traffic being generated. The airwaves would quickly jam up and render communications impossible. Nevertheless, when multiple agencies respond and when command responsibilities transcend individual organizations, common sense dictates that operational team leaders should be able to communicate easily with one another and up the command chain. Individual first-line responders need to understand their orders, even if they are being directed by a superior from a different service. Above all, the incident commander needs direct and effective lines of communications with those below him or her.

I am of the view that authorities involved in emergency response urgently need to investigate and develop means to achieve inter-service interoperability and compatibility on a provincial level. Examples already exist. I was informed, for example, that the City of Toronto has a joint emergency services channel open to police, fire, and EMS. It is possible to switch to that channel to allow all three agencies to talk during an event. The Office of the Fire Marshal has played a role during past emergency responses, bringing additional radios to the emergency response scene. The OFM radios have a common channel that can be used to enable interoperability of radio systems among different response agencies.<sup>25</sup>

At the policy roundtables, there was widespread support for the notion that different agencies at an emergency response needed common communications technology in order to break down the silos between organizations and to deal, in real time, with urgent operational issues.

**Implementation 1:** Emergency response agencies in Ontario under the aegis and leadership of the Ministry of Community Safety and Correctional Services should be brought together to explore new technologies and to develop communications equipment, systems, and protocols to enhance interoperability during joint rescue and recovery deployments.

**Implementation 2:** In the interim, the Office of the Fire Marshal should continue to maintain a cache of common-frequency radios and/or additional communications equipment to be distributed to the upper command levels of all agencies involved with rescue efforts. Joint training should incorporate use of common-frequency communication.





**Recommendation 2.15**

**Specialized rescue workers must be trained to accept the need for contemporaneous record-keeping during an emergency response. To facilitate the process, waterproof notebooks should be provided and consideration should be given to the acquisition of hands-free recording technology.**

**Rationale:** With the exception of police and the Elliot Lake Fire Department, the rescue and recovery organizations involved in the deployment, in particular HUSAR/TF3, do not appear to have a culture of note-taking during operations. The reason may be related to the practical difficulties associated with note-taking at an emergency scene.

Note-taking by rescue workers during this deployment was subpar, at best. Notes were produced long after the fact, or not at all. Times were off, sometimes significantly. Key events went unrecorded entirely. Although certain individuals (often those from the policing milieu) took good notes, the vast majority of those involved with rescue efforts quickly abandoned attempts to take proper notes or never attempted the process at all. Some blamed the wet environment.

I emphasize elsewhere in these recommendations the important potential for improvement that flows from debriefings and after-action reports. Good notes are essential to that process. The ability surely exists to equip rescue workers with the technology to take hands-free, voice-transmitted notes. I leave the choice of technology to the experts, but cannot stress enough the importance of taking good notes for understanding what happened and improving on it.

**Implementation:** Emergency Management Ontario, the Office of the Fire Marshal, HUSAR/TF3, and UCRT should explore the purchase of hands-free note-taking technology (audio recorders) to be provided to rescuers during rescue operations to supplement or to replace written field notes. Waterproof-paper notebooks and waterproof pens are inexpensive and widely available. Training must stress the importance of contemporaneous note-taking.



## HUSAR/TF3 (Heavy Urban Search and Rescue Task Force 3)

In this section, I make recommendations that are intended to improve how HUSAR/TF3 responds to structural collapses. These recommendations flow from the evidence and hopefully should be taken as constructive criticism. It would be unrealistic to think that an undertaking as big as the HUSAR/TF3 response to Elliot Lake could be done in a manner that left no room for improvement.



### Recommendation 2.16

**HUSAR/TF3 should conduct debriefings in a timely fashion following any deployment.**

**Rationale:** HUSAR/TF3 should critically evaluate its own performance in a deployment to ensure that matters needing improvement are identified and addressed.

Debriefings are meetings typically held very shortly after an event, where the participants discuss their own group's performance and that of other responders in applicable circumstances. They are a critical part of the learning process. A debriefing usually includes those persons who attended an incident on behalf of the organization as well as some supervising personnel. The purpose is to identify and discuss those aspects of the response that were done well and those that were not. Overall, the aim is to learn from the event, so that future deployments do not repeat past mistakes. In debriefings, strategies are developed to eliminate or mitigate the mistakes in addition to building on those aspects that were identified as successes.

HUSAR/TF3 did not hold a debriefing after the Elliot Lake deployment, despite having had opportunities to do so. Moreover, the evidence was that HUSAR/TF3 does not conduct debriefings. The reason cited for this absence is primarily financial. There does not appear to be any source of funding that would cover the cost of bringing the team together after the fact. Based on the evidence heard, it seems clear that debriefings could have been conducted at the hotel the team stayed at in Sudbury on the way home. Alternatively, it could have been done on the bus travelling back to Toronto. Neither opportunity would have required any additional funding since the province was already paying for the team's time. Less satisfactory but useful nevertheless, one could have been conducted by correspondence (electronic or traditional). No explanation was offered for these missed opportunities.

I strongly encourage that this practice change. No one has disagreed with the value that a debriefing holds for an organization. The province, which to date has been the primary deploying agency of HUSAR/TF3, has a direct interest in the quality of the services for which it is contracting.

**Implementation:** The memorandum of understanding between the province and HUSAR/TF3 should be amended to provide that HUSAR/TF3 must conduct debriefings in a timely fashion following any provincial deployment.

HUSAR/TF3's current memorandum of understanding with the province runs until March 31, 2017. It can be amended with the consent of both parties. HUSAR/TF3 and the province should be able to come to an agreement to ensure that debriefings are done. HUSAR/TF3, the Office of the Fire Marshal and Emergency Management (OFMEM), indeed all the citizens of Ontario, want the team to be as effective as possible whenever it is deployed. This type of opportunity to improve should not be lost.



### **Recommendation 2.17**

**HUSAR/TF3 should create an after-action report in a timely fashion following any deployment. In the case of a provincial deployment, the after-action report should be submitted to the Office of the Fire Marshal and Emergency Management (OFMEM).**

**Rationale:** The after-action report documents the successes and failures of a response, as well as steps to be taken to improve performance in the future.

This recommendation is the companion of Recommendation 2.16. The evidence disclosed that, like debriefings, HUSAR/TF3 does not prepare after-action reports. The after-action report can be seen as an extension of a debriefing, where an analysis of the problems identified leads to strategies to deal with them. It creates a documentary record of the plans to improve the group's performance and sets a standard against which progress can be measured.

**Implementation:** The memorandum of understanding between the province and HUSAR/TF3 should be amended, if necessary, so that HUSAR/TF3 is required to create an after-action report and to provide it to the OFMEM in a timely fashion after a provincial deployment.

The MOU states that the City of Toronto is to provide the minister with a written report at least once a year, or more frequently as the minister directs. The report is to include, pursuant to article 8.3:

- training that the City has provided to members of the provincial HUSAR team;
- an account of all occasions on which the provincial HUSAR team has been used; and
- anything else reasonably requested by the minister.<sup>26</sup>

The only documentary record of the deployment at Elliot Lake that was provided to the province was the invoice. It did not provide details of what took place. Article 8.2(c) could be relied on to request an after-action report; however, it has not been used in that fashion to date. Either through reliance on article 8.2(c) or an amendment to the MOU, after-action reports should be provided to the OFMEM. The after-action reports would allow it to be informed of problems and of the progress in resolving them. If the problem involves training issues, then the OFMEM could either provide that training or, presumably, arrange for it.





### **Recommendation 2.18**

**HUSAR/TF3 and UCRT (the OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) should enter into a memorandum of understanding with each other that clearly sets out the command structure under which they will operate when jointly deployed.**

**Rationale:** A clearly defined and well-understood chain of command is essential to the safety and success of the response.

These two specialized teams have not trained together frequently and have been jointly deployed on only a few occasions. There is no formal protocol governing how they will operate in these circumstances.

At Elliot Lake, there were different expectations about what the command structure between them should be. Both teams were there in support of the local authorities and were therefore under the command of Chief Officer, who was the incident commander. It was clear to all that, because of their expertise, the two teams would be the backbone of the Operations Section.

The question became who would lead the Operations Section. In the past, there had apparently been discussions about formally defining their roles and command. However, these discussions did not produce tangible results, as was evidenced by the divergent and often contradictory views that witnesses expressed about how UCRT and HUSAR/TF3 should interact in a command structure. For example, even within HUSAR/TF3, there were differing views expressed about the relationship between it and UCRT. Capt. Comella's expectation at Elliot Lake was that the command structure would be one of unified command, with a leader from all responding agencies. In such a scenario, Capt. Comella felt UCRT would have a command position equivalent to HUSAR/TF3. Staff Insp. Neadles, on the contrary, expected that the UCRT team would have a presence in the command tent but that it would fall under the direction of HUSAR/TF3. In addition, as I have previously noted, the members of UCRT expressed frustration with the command and control of HUSAR/TF3. Some members of UCRT described "constant battles" and other frustrations with the command and control of HUSAR/TF3.

The evidence heard at the Inquiry clearly showed the need for a formal agreement specifying the command structure when the teams are jointly deployed. Indeed, this proposal received support from high levels within both the OPP and HUSAR/TF3, including Chief Supt. Robert Bruce and Staff Insp. Neadles.

**Implementation:** HUSAR/TF3 and UCRT should enter into an MOU that clearly states what the command structure will be in joint deployments.

At the policy roundtables, it was suggested that a better way to achieve this clarity and understanding of the command structure would be through joint-training opportunities where both teams could work together as a team and build relationships. However, no joint training had taken place in the more than 17 months that had elapsed from the time of the collapse until the roundtables on December 5, 2013. There are no plans for future joint training. Failing joint training, an MOU would at least clarify the relationship in a joint deployment. Ideally, both should occur.



### **Recommendation 2.19**

**HUSAR/TF3 should implement procedures to ensure that qualified section chiefs are available for deployment.**

**Rationale:** The team needs to know in advance that these positions can be filled.

This recommendation deals with leadership staffing. The Elliot Lake deployment disclosed two different problems with staffing: an inability to properly staff a leadership position (the planning section chief), and an overall low turnout. I have outlined earlier how the deployment suffered from the lack of a properly trained planning section chief. At the time of the deployment, the team had only one such member, and he was not available to deploy. Since Elliot Lake, two additional individuals have been trained and certified as planning section chiefs. The team's management recognized and rectified this deficiency. However, addressing a lack of qualified personnel is one thing; ensuring availability to deploy is another.

**Implementation:** Those team members identified as section chiefs for operations, logistics, and planning should be included in the rotational on-call system currently in place for the team's site commander.

Staff Insp. Neadles deployed to Elliot Lake because he was the site commander on call. This practice allowed the organization to know and count on the fact that, if the call came, he would be available to go. Deputy Chief Ronald Jenkins, the project leader for HUSAR/TF3, said at the roundtables that collective agreements could be an issue with adopting this type of procedure in the case of non-management team members. However, he thought all persons in the leadership roles were, in fact, management in their home services. This uncertainty should be removed for other members of the team occupying key leadership functions.

The particulars of organizing a proper roster and its training requirements are matters properly left to HUSAR/TF3's experience and knowledge.



### **Recommendation 2.20**

**HUSAR/TF3 should implement procedures to reduce or eliminate the unpredictability of the size of the team it is able to muster following a call-out.**

**Rationale:** Leaving the size of the team to chance is not prudent planning.

The team membership is over 100. At the roundtables, Deputy Chief Jenkins put the number at approximately 130. When the call-out happened on June 23, 2012, the team deployed 33 members. This turnout was low and may well have been even lower had it not been for the fact that the team was conducting training that day.

I recognize that every response does not require a full team deployment. The number of members required, as previously discussed, is subject to several variables. According to the MOU, a full deployment is 68 members; the HUSAR/TF3 PowerPoint presentation notes that a provincial deployment is 76 members. To field a full team, therefore, would require a turnout of approximately 50 percent. This number should be contrasted with the roughly 25 percent that ultimately deployed to Elliot Lake. Clearly, steps should be taken to ensure that it can field enough members to be able to function effectively.

With the exception of the lack of a planning officer, I do not feel that the low turnout affected the response. However, that may not always be the case.

**Implementation: HUSAR/TF3 should implement a series of point-in-time evaluations to get a better understanding of its ability to field an adequate team and take any remedial steps that the surveys call for.**

Ontario Mine Rescue conducts a series of point-in-time evaluations. These are simply a survey of all the trained responders at a particular site. They are called and asked: "If there was an incident right now, would you be able to respond?" In this way, the organization gets a feel for their staffing requirements.

HUSAR/TF3 could do the same and similarly get an understanding of these trends. For example, it might reveal that typically they get 50 percent response. This would provide a baseline from which to work. How team management deals with the results of the surveys is a matter for its discretion and experience. I acknowledge that it could be a complicated issue involving collective agreements and funding.

Another technique was described by Chief John Hay of the Thunder Bay Fire Department. He informed the policy roundtables that in Thunder Bay they do cold calls. The team members are called in without forewarning but they are not told that it is simply a dry run until they arrive. When they do arrive, they engage in training. He does these cold calls for the purpose of making sure that, when the time comes, he can mount as full a team as possible. Chief Hay determined that, to be able to obtain two 10-person teams to sustain a 24-hour operation, he needs to have 40 trained responders.



### **Recommendation 2.21**

**The HUSAR/TF3 site commander should be supplied with a scribe on all deployments.**

**Rationale: A scribe's notes will allow a site commander to make a full account of his or her actions and decisions.**

Staff Insp. Needles said that, because of the low turnout, he did not feel he could take a rescuer away from the site to act as his scribe. The lack of a scribe clearly handicapped his ability to reconstruct events and explain important decisions during the deployment. This situation was exacerbated by the sparse documentary record kept by HUSAR/TF3 generally.

**Implementation: The position of scribe, although important, does not necessarily require a trained team member. Less qualified members or a civilian could fill this position.**



The position of scribe requires note-taking ability, not rescue skills. It is important that the role be filled. I see no reason why the position should be filled only by a trained rescuer. The overwhelming majority of Staff Insp. Needles's time was spent outside the hot zone. The scribe could come from the ranks of those members who have yet to qualify to work in the hot zone, it could be a driver, or it could be a civilian. It seems to me that this issue was a big problem with a relatively simple solution.



### **Recommendation 2.22**

**HUSAR/TF3 should ensure that it has access to qualified drivers to transport the cache of equipment on deployment.**

**Rationale:** A delay in securing drivers could delay the deployment time; an inability to get drivers could ground the team's equipment.

The evidence disclosed that the team looks to its lead driver, Paul Demy, to line up both the drivers and the tractors needed to transport the equipment. In this case, he had difficulty obtaining drivers. The team turned to Don Sorel from Toronto Water to arrange for drivers. In the past when the team came up short through Mr. Demy, Toronto Waste had supplied drivers. This arrangement, I understand, was simply an informal one. As discussed earlier, it appeared that it ended shortly after this deployment. I do not know if steps have been taken to ensure a back-up plan for drivers. This issue needs to be addressed.

**Implementation:** HUSAR/TF3 should ensure that there is an alternative pool of drivers available if the primary source is not able to provide an adequate number.

These simple details must be worked out and planned for prior to call-out, not during a deployment.



### **Recommendation 2.23**

**HUSAR/TF3 should explore additional sources for tractor rentals.**

**Rationale:** As with the tractor drivers, any delay in securing tractors can potentially delay the time of departure for the team.

Mr. Demy also experienced trouble tracking down the tractor rentals needed to pull the equipment trailers. The tractors were ultimately located in Mississauga, roughly 25 kilometres from the base of operations. According to an email sent by Staff Insp. Needles, the delay in getting the tractors delayed the departure by 30 to 60 minutes. The delay would have been much greater had the deployment occurred on a weekday morning at the height of rush hour.

**Implementation: HUSAR/TF3 must improve the rapid availability of tractors.**

Little evidence was led concerning the rental protocol in place in 2012. I heard no evidence concerning the number and location of leasing companies in proximity to the home of operations. I am consequently unable to make specific recommendations to correct this situation, but, left unremedied, it may mean serious delays in mobilization.

**Recommendation 2.24****HUSAR/TF3 team members should receive training for rigging operations.**

**Rationale:** The cranes of Millennium Crane played a significant role in advancing the progress of reaching the victims, which required trained riggers to complement the hoisting by Millennium.

HUSAR/TF3 personnel made it very clear when they testified that cranes and rigging operations are a method of last resort. It would appear that HUSAR/TF3 team members currently do not receive rigging training. It is not part of the core training courses. Members of HUSAR/TF3 who have completed Rescue Systems 2 would have received between four and six hours of rigging training, according to Capt. Comella. However, those team members would generally be the instructor group that received their training before it was done in-house, in approximately 2005. The team relied on Mr. Sorel for its rigging capability. In contrast, UCRT was more willing to embrace rigging. Its members had received rigging training because they had taken the course identified as Rescue Systems 2 at Texas A&M Engineering Extension Service. It appears obvious to me that circumstances may necessitate the use of cranes at a structural collapse. Unless the team members are trained to rig, they will not be able to use a crane. In Elliot Lake, it was only because Mr. Sorel was present on the deployment that HUSAR/TF3 had some capacity for such operations. By not training for rigging operations, HUSAR/TF3 is limiting the tools and solutions it can use to save lives.

**Implementation: HUSAR/TF3 should make rigging a core skill that all current and new members must acquire.**

I am mindful that this recommendation does not come without cost. How this additional training is phased in will be a management decision. The goal, however, should be that, as soon as possible, the team should develop the capability to field enough of its members to be able to sustain 24-hour rigging operations if required. This does not mean that everyone in the deployment has to be able to rig tomorrow. In a recovery, there is no premium on speed. In a rescue, however, speed could make the difference between life and death. Safety concerns may preclude rigging; lack of training should not.



### Recommendation 2.25

**Standard operating procedure for HUSAR/TF3 should require fully documented incident planning, which is provided to supervisory personnel.**

**Rationale:** The deployment had significant communication issues within HUSAR/TF3. This requirement of fully documented incident planning is intended to ensure that communication of this critical information takes place and is clear.

I have commented on the lack of communication surrounding the incident action plan. This problem could have been avoided if HUSAR/TF3 had used its own incident planning documents. These forms contemplate that an incident action plan will be completed following each formal planning meeting conducted by the incident commander and the staff. The plan is to be reproduced and given to all supervisory personnel. It describes the general objectives for the incident, including variations. It includes a list of assignments, what was accomplished last operational period, and what must be accomplished this operational period.

**Implementation:** HUSAR/TF3 should use its own forms.

The evidence established that there currently exists a more recent version of the planning documents described. These documents are available in hard copy as well as electronically. This recommendation does no more than exhort HUSAR/TF3 to follow its own protocol. With a trained planning officer on deployment, this practice should be standard operating procedure.



### Recommendation 2.26

**HUSAR/TF3 should receive adequate funding to ensure that it is properly equipped and trained to respond to structural collapses in a timely manner with sufficient personnel and expertise. The Joint Emergency Preparedness Program (JEPP) funding should be reinstated by the federal government.**

**Rationale:** Without adequate funding, HUSAR/TF3 will not be able to fulfill its intended function in the future.

The federal government established the National Urban Search and Rescue Program in 2001.<sup>27</sup> It provided aid to member teams through JEPP. HUSAR/TF3 received significant financial support from JEPP. According to the written submission of the City of Toronto for the policy roundtables, the JEPP funding varied from year to year, from a high of \$1.4 million to a low of \$460,000. In 2012, HUSAR/TF3 received \$300,000 from the province, \$400,000 from the City of Toronto, and \$468,000 in federal funding.



At the roundtables, there was unanimous support for the HUSAR/TF3 program as well as recognition of the problem created by the cancellation of the JEPP funding. The province in its written submission at the roundtables put it this way:

Ontario's risk – including its current building infrastructure, geography and make up of its communities – presents challenges that would most effectively and efficiently be addressed by a HUSAR team. HUSAR has the ability to address a massive structural collapse and provide extended substantial response ... The loss of JEPP funding from the federal government may pose fiscal challenges for the continuation of the HUSAR team.

The roundtable discussions made clear that a HUSAR team is needed as part of a federal / provincial program. There is a need for a team that can be self-sustaining for lengthy periods. The Calgary HUSAR team, which responded to the fires in Slave Lake, had to be totally self-sustaining for 16 days.

The federal government has not restored its funding. Canada's heavy urban search and rescue resources continue to struggle in its absence. At the policy roundtables, Coby Duerr of Calgary's TF2 team stated that, without funding from the federal government, the heavy teams in Canada are "holding on for dear life."<sup>28</sup> He advised that Calgary's TF2 team has been unable to compensate for the loss of federal funding:

**The Commissioner:** Has Alberta solved the TF2 funding problem with the absence of Federal funding?

**Mr. Duerr:** No, we have not. So we have done as much as we – we have lobbied as much as we can to the Federal entities and to try and re-establish funding through some form that exists or does not exist that needs to be created.<sup>29</sup>

A number of the recommendations I make in this part come with a cost. For example, in order for HUSAR/TF3 to be able to respond with a full provincial team, membership may need to be increased. This expansion will lead, in turn, to increased training and equipment costs.

**Implementation: JEPP funding should be re-established. The City of Toronto and the province should re-examine and readjust the current funding model to ensure that HUSAR/TF3 not only survives but also can implement these recommendations.**

HUSAR/TF3 is a national, provincial, and municipal asset. All three levels of government have a shared interest in its healthy existence. Fortunately, HUSAR/TF3 is not deployed frequently because, to date, structural collapses have been relatively rare events. However, when they do occur, lives can depend on the quality of the rescue. These dedicated and brave rescuers need the financial support of all levels of government to do their job. In Ontario, Canada's most populous province, the only heavy urban search and rescue asset is operating without any financial support from the federal government. This lack of federal funding is unacceptable, short-sighted, and arguably reckless. The obligations to fund urban search and rescue capabilities should not be borne by the province and municipalities alone.



## UCRT (The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team)

As the narrative and analysis sections of this Report highlight, there is much to be commended in the deployment of UCRT in response to the Algo Centre collapse – including the rapidity and obvious urgency of its mobilization and the team's early recognition of the need for a crane. However, one aspect of its deployment merits appraisal and commentary. The recommendation I make below addresses my concern.



### Recommendation 2.27

**The OPP should implement a duty roster requiring**

- (a) a minimum number of commanding officers who can serve in the command structure of an emergency response and represent UCRT therein; and**
- (b) a sufficient number of commanders who can lead UCRT forces on the ground and be available to respond in a deployment.**

**Rationale:** UCRT must ensure the constant availability of a senior commander in the structure of its emergency response as well as appropriately ranked commanders to lead the UCRT forces on the ground.

The conceptual command structure at the time of the deployment of UCRT was as follows: the unit commander, a staff sergeant, was in charge of the entire UCRT team; below the unit commander, the USAR and the CBRNE elements of the team were each led by a sergeant; in addition, there was a fourth sergeant in an administrative and operational support role.

The staff sergeant in command of UCRT was unavailable to deploy to Elliot Lake. The sergeants in charge of the USAR and the CBRNE elements of the team were on vacation. Accordingly, as the administrative sergeant, Sgt. Gillespie was the highest-ranking officer to deploy with the team.<sup>30</sup> As I described earlier in this Report, the lack of higher-ranking UCRT officers caused a number of issues during the emergency response.

Even though UCRT was performing essentially the same operational function as HUSAR/TF3, it did not have any material representation or input at command meetings or in the development of the strategy of the response. For example, Chief Officer, the incident commander, did not even consider anyone from UCRT to be part of the command structure at all.<sup>31</sup> He thought UCRT got “rolled up” into HUSAR/TF3 within the command structure.<sup>32</sup> Because he was alone in the command of UCRT, Sgt. Gillespie had to choose between commanding his forces on the ground and participating in the command of the emergency response. He chose the former, a decision which I do not criticize.

UCRT did not participate in key decisions during the operation, including the decision to call off the rescue. It was not in a position to provide any input to Chief Officer or anyone else in the command structure. Given UCRT's depth of training and experience, its omission from the command structure was detrimental to the operation generally.

In addition, UCRT's absence from the command tent likely contributed to the frustration expressed by many of its members about uncertainty related to the command structure during the emergency response, the lack of briefings, and the manner in which they perceived they were being treated by HUSAR/TF3 command personnel. UCRT contributed ably to the operational elements of the Elliot Lake rescue operation. By having properly trained and appropriately ranked officers in its command structure, many of those frustrations could have been alleviated.

In any future deployment of UCRT, there should be a sufficient number of properly trained and appropriately ranked commanders to: (a) represent UCRT in the command structure of the emergency response; and (b) command the UCRT forces on the ground. In my view, the OPP should establish a duty roster to ensure that an adequate number of UCRT leaders are available to participate in any deployment of the team at all times. Establishing a duty roster for this purpose will prevent UCRT from being in a position where only one of its four sergeants is available to deploy with the team.

It is clear that the OPP is alive to these issues and intends to beef up its own command presence for any future UCRT deployments. In its after-action report, it noted that it is "critical" that the above-described leadership gaps be filled, and the report makes a number of recommendations with respect to command and control of UCRT which I summarized earlier in this Report.<sup>33</sup> Those recommendations appear entirely logical and well reasoned.

**Implementation:** The OPP should implement a duty roster requiring that a sufficient number of properly trained and appropriately ranked commanders will be available to respond in any deployment to:

- (a) represent UCRT in the command structure of the emergency response; and
- (b) command the UCRT forces on the ground.

## Speed of response

By its very nature, the response to an emergency must be as rapid as possible. In any collapse situation, the difference between a successful rescue and a tragedy may be a matter of minutes.



### Recommendation 2.28

**There should be more training of HUSAR/TF3 and UCRT members on the utility and capability of cranes in rescue operations.**

**Rationale:** HUSAR/TF3 and UCRT members should have a better understanding of the utility and capability of crane operations in responding to a structural collapse. This understanding will allow Ontario's rescuers to identify when a rescue situation calls for a crane.



I have previously commented on Cst. Cox's early recognition of the necessity for a crane to assist in rescue operations. His request for one came soon after the deployment of UCRT. Conversely, I have found it concerning that the leaders of HUSAR/TF3 did not similarly recognize its evident utility. For example, on viewing a photograph showing the debris pile consisting of large pieces of concrete slabs and an SUV, Staff Insp. Needles testified he would not likely have ordered a crane:

- A. Well, that picture doesn't tell me a lot. It doesn't tell me I need a crane or I don't need a crane ... I don't – I can't put that picture in perspective. Just seeing that picture, I don't have a depth gauge on where that is in the mall, where it sits, how it fits or ... if the victims are perceived or found or anything located anywhere near this. I don't know.
- Q. Well, if you had received information that what you are looking at here is part of the collapse zone, and we have got people under that material, would that change anything for you?
- A. You are asking me to speculate. Would I have? Possibly but possibly not. I probably would not have ordered a crane.<sup>34</sup>

Cmdr. McCallion candidly acknowledged that he did not have the necessary knowledge of crane operations to know whether a crane could be useful to the rescue based on photographs of the site. He testified as follows:

- Q. Right. Would you not think that it would be prudent to make that call [to request a crane], rather than have 7 hours go by, when you could see for yourself, and then make the call? You've lost 7 hours.
- A. Sure.
- Q. It may have caused you some money but that's really the only downside, is it not?
- A. Well, no, because you – part of our training is not to utilize crane operation as part of our primary assessment or primary ability to get into, sort of, rescue victims and also, how would I know what – I'm not a crane operator, I don't know what the mechanics or the engineering requirements of a crane are so how would I know based on those pictures, what type of crane I would require?<sup>35</sup>

The subsequent crane operations in Elliot Lake vividly illustrate their utility. Cmdr. McCallion's response makes plain that knowledge of, and training in, crane operations is essential. In fairness, when Cmdr. McCallion left for Elliot Lake, it was his expectation that he would be the medical manager. It was only after he arrived in Elliot Lake that his role changed and he became a site commander for the first time. However, he does confirm that, according to current training, resort should not be made to crane operations, at least initially.

Similarly, Capt. Comella testified that ordering a crane would not have been a priority for him, even on seeing the photographs of the collapsed zone.<sup>36</sup>

Dave Selvers, who has made a career as a crane operator, testified that, from photographs showing slabs, an automobile, and other debris on the pile, it would have been clear to him that a crane would be needed to remove material from the collapsed zone:

- Q. Tell us from your experience whether you would know whether a crane would be required in order to remove that type of debris from a hole like this ...
- A. Immediately.
- Q. ... And why do you say that Mr. Selvers?
- A. There is no other way of removing material of that – that size and that weight, including an automobile. It has got to come straight out of the hole. Nothing is going to be taken out – well, in order to remove that stuff, you must have to bust it into pieces no more than 50 pounds of piece for a human being to safely remove. And that is going to take quite a long time.<sup>37</sup>

I have recommended that HUSAR/TF3 make rigging a core skill that all new and current team members must acquire. The OPP, in its after-action report, called for expanded training to more members of UCRT in rigging and crane operations. It is my recommendation that this training include educating these rescuers on the utility and general capability of crane operations.

**Implementation:** HUSAR/TF3 and UCRT should educate their members on the utility and general capability of crane operations. This training would allow both teams to recognize those circumstances when crane operations represent a superior strategy. If the teams have rigging skills, then they would have the tools to implement the strategy.



### **Recommendation 2.29**

**HUSAR/TF3 should send advance teams to a collapse site ahead of the full team.**

**Rationale:** Advance teams provide opportunities for valuable reconnaissance and other preparation for rescue operations.

I have already commented favourably on the rapid mobilization of UCRT. An integral part of the team's effective and speedy deployment was the fact that Cst. Cox departed for Elliot Lake ahead of the rest of his team, and he was given authority over the team until his superior officer arrived in Elliot Lake. By not waiting for the entire team to be ready to depart its base in Bolton, Ontario, Cst. Cox was able to:

1. conduct reconnaissance work while en route to Elliot Lake, including reviewing photos of the scene on the Internet;
2. assess the need for essential equipment, material, and services and request their procurement;
3. arrive in Elliot Lake early to be briefed by the emergency response leaders on the ground; and
4. be in a position to brief his team on its subsequent arrival in Elliot Lake and immediately begin the process of developing a plan to continue the reconnaissance.

Understandably, as a heavy response team, HUSAR/TF3 cannot deploy as rapidly as UCRT. Given that characteristic, HUSAR/TF3 should, where possible, deploy a smaller group of members in advance of the larger team. This advance deployment would allow the team to get a first-hand appreciation of the scale of the emergency response work ahead of it and to better assess the additional resources it may require. It could work in conjunction with the UCRT advance team, if UCRT is deployed, and with local responders to gain early intelligence about the scale of the emergency and to conduct joint reconnaissance. Work on an incident action plan could begin at this early stage without waiting for all teams to arrive.

**Implementation:** The memorandum of understanding between the Province of Ontario and the City of Toronto in respect of HUSAR/TF3 should require, where possible, that HUSAR/TF3 have an advance team of its members deployed in advance of the balance of the team.



### Recommendation 2.30

**The OPP (and all initial first responders) should forward as soon as possible to the deployed rescue team any photographs that have been taken of an emergency.**

**Rationale:** Photographs will assist rescuers in assessing the emergency scene and in determining the need for additional resources.

Insp. Jollymore ordered Cst. Dale Burns to photograph the collapsed zone both from the air and from the ground. However, these photographs did not find their way to the rescuers who were, at that point, making their way to Elliot Lake. Cst. Cox did not see Cst. Burns's photographs until he arrived in Elliot Lake himself.

Good photographs can be of considerable assistance in the reconnaissance of the site of an emergency response. Cst. Cox was able to identify the need for, among other things, a crane and a structural engineer from the photographs that he saw on the Internet. The photographs taken by Cst. Burns, because of their quality, would almost assuredly have been very useful to Cst. Cox and to the members of HUSAR/TF3. Throughout the hearings, I relied heavily, as did all counsel, on the photographs that were taken by Cst. Burns in the hours after the collapse.\*

In addition, it would have been useful for rescuers to have these photographs for forwarding to related service providers. Mr. Selvers testified that photographs would have been of material assistance to him:

Q. Would photos would have been a help to you?

A. It would have been a big help, yes.

Q. And why is that?

A. It would give us a better understanding other than a somewhat distorted media perspective.

Okay. If we had things emailed to us, it would – it would just – it would make our calculations, our assumptions, a word I don't like to use – but it would be more precise.

Q. And when you say "a distorted media perspective", is that a reference to the imagery you told us earlier you had seen on the television?

A. Correct.<sup>38</sup>

In addition, Staff Insp. Neadles testified that photographs more clearly showing an SUV in the collapse zone would have influenced his decision about ordering a crane.<sup>39</sup>

Digital photography allows for the rapid electronic transmission of high-quality images. Those images hold information that is critical to the trained eye of the rescuer. In my view, those who could use the images the most should be the first to see them.

**Implementation:** The OPP should adopt a policy of forwarding, as quickly as possible, any photographs taken of a scene that will be the site of an urban search and rescue operation to rescuers being deployed to that scene. Organizations such as the Office of the Fire Marshal or Emergency Management Ontario should similarly advise local responders.

.....

\* For a collection of some of the most representative and useful photographs, please see Exhibit 7924.





### **Recommendation 2.31**

**HUSAR/TF3 should mobilize and deploy with all practicable speed. Impediments to rapid deployment should be eliminated.**

**Rationale:** In any rescue scenario, time is always of the essence. In the current deployment practices of HUSAR/TF3, there appear to be opportunities for increased efficiencies and mobilization speed.

Currently, HUSAR/TF3 has a benchmark deployment speed of six hours from call-out to mobilization.<sup>40</sup> It mobilized in just less than six hours in response to the Mall collapse in Elliot Lake.

#### *The team members underwent physicals before boarding the buses*

When HUSAR/TF3 team members assembled at their muster point in Toronto, they received a brief physical from either a doctor or a paramedic, in which the team members discussed their health with the medical professional. The purpose of the physical was to ensure they were healthy enough to undertake the arduous tasks ahead.<sup>41</sup> More specifically, these physicals are considered necessary to prevent illness from spreading and incapacitating a significant proportion of the response team. That is a desirable objective, but it must be weighed against the importance of a rapid response.

I am of the view that it is a step that could be eliminated and replaced with a self-reporting obligation requiring that members disqualify themselves if they feel ill or are exhibiting any symptoms of illness or a communicable disease. In addition, a thorough annual medical examination should be a prerequisite for service as a team member if one is not now required.

#### *The team received a briefing before departing*

After team members received a physical, they were briefed on the information available by the site commander.<sup>42</sup> This debriefing is something that could easily be done en route on the team bus – particularly so considering the team's commanders, including Staff Insp. Neadles and Cmdr. McCallion, travelled to Elliot Lake on the bus.

#### *The vehicles travelled in a convoy*

The HUSAR/TF3 support vehicles met up with the team bus at a Petro-Canada station north of Toronto in order to travel to Elliot Lake in a convoy. I fail to see the benefit of the team's vehicles travelling in a convoy. In this age of GPS technology and widespread cellular phone availability, there is, on the one hand, a diminished prospect of getting lost or being slowed in circuitous routes. On the other hand, there is great benefit in arriving at an emergency scene as quickly as possible.

#### *Difficulties in arranging for transport vehicles*

As I described earlier in the Report, the team encountered the following obstacles in arranging for transport vehicles:

- There were difficulties in arranging for the rental of tractor transport vehicles.
- There were difficulties encountered in securing the services of drivers for the tractor transport vehicles.

- The closest available tractor transport vehicles were located in Mississauga. Consequently, the drivers had to be driven to Mississauga to pick up the vehicles, and then had to return to the muster point.

Earlier recommendations address the logistical improvements that can be made to the way in which HUSAR/TF3 organizes its transportation requirements. These improvements are imperative. The Elliot Lake deployment occurred on a weekend. It does not take much imagination to consider what the delay would have been had the need for tractors been on a busy workday morning. Traffic congestion at that time of day would have caused additional substantial delays getting tractors to the home of operations.

### *Contrast with the rapid response of UCRT*

The rapid response of UCRT presents a rather stark contrast. Sgt. Gillespie acted with commendable good judgment and haste in mobilizing his team, even though he had to break with UCRT protocol by doing so before his superior officers had approved his decision. He testified that he made this decision “based on the urgency, that the facts were that people were trapped and we needed a response so I did not expect any issue. I was unable to get a hold of my chain of command so I made that decision on my own.”<sup>43</sup>

Sgt. Gillespie quickly delegated command of the team to Cst. Cox, who could go to Elliot Lake sooner than the rest of the team. The other members of UCRT rapidly mobilized and arrived in Elliot Lake in impressive time.

**Implementation: HUSAR/TF3 should, in its training exercises and logistical planning, seek to mobilize itself with all practicable speed. It should re-examine its pre-deployment procedures and take measures to ensure the rapid availability of transport vehicles. The six-hour benchmark to deploy should be viewed as the outside limit of permissible mobilization time, not a target.**

## Ministry of Labour

I heard evidence during the Inquiry of widespread confusion about the role and powers of Ministry of Labour (MOL) engineers and inspectors at the scene of a rescue or recovery operation. This confusion existed among the rescue workers but also within the ministry itself. At the outset of the rescue, a false rumour circulated that the MOL had ordered a stop to rescue efforts. Many openly questioned whether the ministry actually had the power to do so. Throughout the rescue, uncertainty about the MOL's role and powers persisted. When the stoppage occurred on June 25, suggestions again circulated that the MOL had shut down the rescue, when in fact the decision had been made by Staff Insp. Needles. Further confusion ensued with respect to MOL jurisdiction at the scene once rescue efforts had ceased.

I also heard concern expressed during the roundtables, notably from the fire protection community, that the mere presence of MOL personnel at the scene of a rescue or recovery can have an unnerving effect on incident commanders, causing them to potentially second guess decisions.

MOL employees, including experienced ones such as the provincial engineer, Mr. Jeffreys, expressed uncertainty about the scope of ministry powers and how to use them at a rescue or recovery operation. He suggested that, at a recovery operation, he would at least threaten to issue a stop work order if his warnings about a clearly dangerous situation were ignored. He also suggested that, in a rescue situation, there was an “implied statement,” flowing from the fact that first responders cannot refuse unsafe work, that the MOL would not act to stop a rescue unless something was “patently unsafe.” I heard different opinions from others. Everyone seemed to be formulating their own opinions with little guidance.

Although far from a regular occurrence, it was not the first time that Ministry of Labour personnel had been present during ongoing rescue or recovery operations. Mr. Jeffreys had been asked and had provided input on how to safely proceed with recovery operations in the past. Scott Campbell, a participant at the roundtables from the Ministry of Labour, said that he too has been at a rescue or recovery scene and drawn potential hazards to the attention of the local incident command. Mr. Gyska of Ontario Mine Rescue, whose experience comes from mine rescues, said the Ministry of Labour typically stayed away from the scene until rescue or recovery was complete. No one was aware of a situation where the MOL had actually ordered work stoppage at a rescue or recovery operation.

The situation will arise again. Ministry of Labour personnel will again be present at the scene of an ongoing rescue or recovery, and the same confusion will arise. To my knowledge, no one from the Ministry of Labour and no one from search and rescue has been trained on the role and powers of the ministry at an ongoing rescue or recovery operation. Individuals questioned on the scope of MOL powers essentially engaged in their own exercise of statutory interpretation and perceived common sense. The result was confusion.



### **Recommendation 2.32**

**Ontario should clarify the roles and responsibilities of Ministry of Labour inspectors and engineers at the scene of an ongoing rescue or recovery effort.**

**Rationale:** The role of the Ministry of Labour at ongoing rescue and recovery operations remains a source of confusion and has the potential to impede future emergency response operations if not clarified.

The Ministry of Labour prepared a useful submission outlining the roles and powers of MOL personnel at an emergency scene.<sup>44</sup> As indicated, the scene of a rescue or recovery operation has been deemed by the courts to be a workplace.<sup>45</sup> The *Occupational Health and Safety Act* (OHSA) applies at all times to all workplaces under provincial jurisdiction and may be enforced by the MOL.<sup>46</sup> Thus, an inspector at the scene of a rescue who finds that a provision of the OHSA is being contravened can order compliance, even going so far as to issue a stop-work order.<sup>47</sup>

Sections 43 and 44 of the Act stipulate that certain workers, such as police and firefighters, cannot refuse to work in dangerous circumstances if the danger is inherent in their work or is a normal condition of employment, or if refusing the work would directly endanger the life, health, or safety of another person.<sup>48</sup> I am not aware of any corresponding limitation or guidance related to the power of inspectors to issue stop-work orders at the scene of a rescue or recovery.

Some roundtable participants advocated for the abolition of the MOL power to stop a rescue or recovery operation. This option would mean that first responders would have no workplace safety protection at all. I do not think it would be wise as a matter of policy. I agree with the following conclusion from the Ontario Labour Relations Board:

[W]orkers who engage in inherently dangerous work for the benefit of the public have a right to expect that their employers and the Ministry of Labour will be especially vigilant in ensuring that all reasonable precautions consistent with the performance of their duties will be taken.<sup>49</sup>



I do, however, find a pressing need for clarification, education, and guidance about the role of the MOL at rescue and recovery operations. If anything, the publicity surrounding the perceived role of the ministry in shutting down rescue efforts in Elliot Lake has added to the confusion about the role and powers of MOL inspectors and engineers at emergency scenes.

**Implementation:** The Government of Ontario should develop guidelines and training on the role and powers of MOL personnel at both rescue and recovery operations. The guidelines and associated training should be provided to all key actors in the rescue and recovery milieu, including the Office of the Fire Marshal, Emergency Management Ontario, HUSAR/TF3, UCRT, MOL, other urban search and rescue teams, and the municipalities.

Guidelines must be created to set out the role and powers of MOL inspectors and engineers at the scene of rescue or recovery operations. Those guidelines should set out when it is appropriate for a ministry inspector to offer advice and what steps the inspector or engineer might take if that advice is not heeded. The guidelines should draw a clear distinction between the role of the MOL at the scene of a perceived rescue (where there are potential live victims) and its role at a recovery (deceased victims only). Logically, the permissible risk would be greater where people's lives can still be saved.

The training materials and guidelines should make it clear that the MOL continues to have jurisdiction at a rescue or recovery operation but will not, as a rule, use the power to stop work unless certain conditions have been met. The guidelines should take into account the primary role of the incident commander at the scene, and the obvious fact that he or she is far more likely than MOL inspectors to have expertise in rescue or recovery operations, or access to that expertise. Any guidelines should include close collaboration and communication between ministry personnel and the incident commander and appropriate deference to the specialized expertise of the rescue workers. MOL personnel might be encouraged to provide advice and be an extra set of eyes for hazard-spotting, while leaving the decision to stop the rescue, to the fullest extent possible, with the local incident commander.



### Recommendation 2.33

**The Ministry of Labour should use section 21 committees to further ensure that first responders are knowledgeable about the role and authority of the ministry and how it compares and contrasts with their own responsibilities during an emergency.**

**Rationale:** Section 21 committees, created pursuant to the corresponding section of the *Occupational Health and Safety Act*, were described during the roundtable process as useful forums for addressing outstanding issues in the area of workplace safety.

Under section 21 of the OHSA, committees have been set up to advise the Ministry of Labour on specialized occupational health and safety matters. They are referred to as section 21 committees and are co-chaired by labour and management representatives from the occupational field that is the focus of the committee. The Ministry of Labour works collaboratively with these committees and they regularly develop guidance materials.

Committees exist for firefighters and for police. A health care committee exists, with a subcommittee dealing with emergency medical services issues.

During the roundtables, I saw support for using the section 21 committees as a vehicle for better understanding how the MOL and rescue workers can work together at an ongoing rescue or recovery scene.

**Implementation:** Existing or new section 21 committees should be used to initiate dialogue among emergency responders in Ontario and the Ministry of Labour in order to develop the guidelines and training discussed in the preceding recommendation.

## Debriefings and after-action reports

As I stated earlier in these recommendations, debriefings and after-action reports are a critical part of the learning process. They usually include those persons who attended the incident on behalf of the organization, along with some supervising personnel. The purpose of a debriefing is to identify and discuss those aspects of the response that were done well and those that were not. Overall, the aim is to learn from the event and improve, so that future deployments do not repeat past mistakes. Debriefings and after-action reports allow the development of strategies to eliminate past errors and to build on successes.



### Recommendation 2.34

**Timely debriefings and after-action reports should be mandatory for all agencies and organizations involved in rescue and recovery operations where an emergency has been declared or where provincial resources have been called in to assist. The after-action reports should be shared among all agencies involved.**

**Rationale:** The opportunity for improvement from debriefings and after-action reports is too important to waste, and too important not to share among all agencies involved.

I have already discussed HUSAR/TF3's failure to debrief and produce an after-action report, but it was not the only agency to fall short in this regard. UCRT held a debriefing, although certain key players were absent, and the OPP produced a comprehensive after-action report relating to all elements of OPP involvement in Elliot Lake. Deployed Ontario Fire Marshal officials did meet, albeit informally, and the Office of the Fire Marshal (OFM) did produce a comprehensive after-action report. Otherwise, I saw an unfortunate lack of discipline when it came to ensuring that proper debriefings and after-action reports were produced. Many excuses were provided. None were acceptable.

The City of Elliot Lake failed to hold a debriefing despite a requirement to do so in its emergency response plan. No after-action report was produced, and the City's emergency response plan did not require that one be created.

The Elliot Lake Fire Department did not hold a debriefing or create an after-action report.

The Ministry of Community Safety and Correctional Services (MCSCS) produced a consolidated after-action report, but not until a year after the event. It did not contain input from HUSAR/TF3 and also contained important misunderstandings of the facts.

The Ministry of Labour played an important role throughout the rescue and recovery efforts, and several MOL inspectors and engineers were deployed to the scene during the rescue and recovery efforts. Despite this involvement, the ministry did not hold a debriefing session or produce an after-action report and, to my knowledge, the MOL was not consulted for input into the after-action report produced by the MCSCS.

All these agencies should have held debriefing sessions immediately or shortly after the event, and should have created after-action reports. These reports, in turn, should be shared among all agencies involved. If Ontario is to learn from its mistakes, and from its successes, in emergency response, these silos must be broken down. The various agencies involved in any large-scale emergency response must be able to learn from each other even when – indeed, especially when – things have not gone as smoothly as hoped and tensions exist.

**Implementation:** The Office of the Fire Marshal and/or Emergency Management Ontario should have dedicated staff or private consultants whose duty it is to facilitate timely debriefings and the creation of after-action reports by all agencies involved, and to assist with their distribution. This should be limited to emergency response operations following declarations of emergency and/or use of provincial resources.

## The Inquiry Process

Every commission of inquiry hopes all its recommendations, in their entirety, will be implemented by governments and other public institutions. However, commissions have only the power to make recommendations. It is for others to decide which recommendations to implement and the timing and method of that implementation. There may be valid reasons for non-adoption, ranging from fiscal imperatives to altered circumstances.

Nonetheless, substantial public funds are expended on inquiries of this nature. Much time and effort has been devoted to ensure that my recommendations are cost-effective, practical, and reasonably achievable. The Commission also aimed to ensure that implementation was likely to attract consensus, support, and approbation from a cross-section of society.



### Recommendation 2.35

**The Government of Ontario and other institutions identified in this Report should issue a public report within one year on their response to these recommendations and what steps, if any, they are taking to implement them.**

**Rationale:** The residents of Elliot Lake and all Ontarians have a right to know whether these recommendations are being implemented and, if they are, how they are being implemented.



I believe the residents of Ontario, and Elliot Lake in particular, have a right to know the extent to which governments and other public institutions will implement the recommendations and the reasons for any deferral or rejection. They should not have to hunt through a series of disparate websites and dense publications to understand what the results of this process have been.

In the Toronto Computer Leasing Inquiry, Madam Justice Denise Bellamy recommended: “At the first Council meeting after the first anniversary of the release of this report, the Mayor should report to Council on progress made in implementing the report’s recommendations.”<sup>50</sup>

The Commission of Inquiry into the Decline of Sockeye Salmon in the Fraser River (2012) recommended:

An independent body such as the office of the Commissioner of the Environment and Sustainable Development should report to the Standing Committee on Fisheries and Oceans and to the public as follows:

...

By Sept. 30, 2015, on the extent to which and the manner in which this Commission’s recommendations have been implemented.<sup>51</sup>

Similarly, the Missing Women Commission of Inquiry recommended:

That the provincial government appoint an independent advisor to serve as a champion for the implementation of the Commission’s recommendations. The appointment should take effect within 12 weeks of release of the Report.<sup>52</sup>

Indeed, in November 2013, the British Columbia government issued a status report on its implementation of the Missing Women Inquiry’s recommendations.<sup>53</sup>

I believe that this recommendation is in keeping with the spirit of the premier’s recently reiterated commitment to lead the most open and transparent government in the country.



## Recommendation 2.36

**The Ministry of the Attorney General should prepare and keep current a tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.**

When my appointment as Commissioner of this Inquiry was announced, I had no previous experience relating to this type of endeavour. Before the Order in Council creating the Commission was promulgated, I met with senior personnel of the Ministry of the Attorney General at a time of transition within the ministry. The appointment of a new deputy attorney general was imminent, and many individuals occupied acting positions.

What I needed most as I assumed my position was a clear road map of what lay ahead for me – a comprehensive “handbook” for newly appointed commissioners, outlining government policies and practices on everything ranging from human resources to budget management. This area was largely “terra incognita” for me. The advice I received from government was gracious and generous, but short on detail. One of the first questions I was asked was how much time I thought the Commission would require to do its work and what I thought the budget should be. I was totally unequipped to even begin to formulate answers to these questions.

Time and money are any Commission's constant worries and unrelenting realities. The *Public Inquiries Act, 2009*,<sup>54</sup> now provides that the Order in Council fix the date for the delivery of the report and that the minister sets the budget.

Initially, I could and did provide some meaningful input into the Commission's mandate, but I felt ill-equipped to provide advice on anything else.

**Rationale: To assist newly appointed commissioners and administrative staff in the efficient creation, organization, and administration of commissions of inquiry.**

Commissioner Sidney Linden, in his *Report of the Ipperwash Inquiry*, recommended that "the Ministry of the Attorney General create a permanent secretariat or repository of administrative expertise and best practices related to public inquiries to provide more comprehensive operational support and guidance to commissioners and administrative staff."<sup>55</sup>

I echo that recommendation.

This will not be Ontario's last commission of inquiry. For the benefit of future commissioners, I recommend the preparation of a comprehensive "kit" that could be given to a newly announced commissioner, even before the official Order in Council, containing such things as:

- a mini-library of previous commission reports;
- current literature on the conduct of commissions of inquiry, such as Professor Ed Ratushny's very useful book *The Conduct of Public Inquiries*;<sup>56</sup>
- jurisprudence relating to past commissions of inquiry;
- an outline of current government legislation, regulations, policies, and practices relevant to the administration of public inquiries;
- a current inventory of reliable service providers available to commissions of inquiry which government and previous commissions have used (e.g., reporting and transcription services, data management experts, media consultants, and audio-visual specialists); and
- a compendium of best practices, to which previous commissioners and government representatives could be asked to contribute.

A copy of the 2012 Draft Public Inquiries Guide prepared by Ministry of the Attorney General, Corporate Services Management Division, was provided to the Commission's executive director shortly after her recruitment. It covers specific administrative and logistical issues involving the creation and operation of inquiries. My staff's suggested modifications to it have already been discussed with ministry staff. The draft guide contains useful information for the person retained to manage a commission, such as identifying the different branches of government responsible for facilities, technology services, or financial matters including setting up the delegation of authority. However, it does not contain any of the elements of the "kit" described above.

**Implementation: The Ministry of the Attorney General should prepare and maintain an up-to-date tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.**

**Recommendation 2.37**

**The Ministry of the Attorney General should appoint an independent assessment officer and pay the accounts of the Participants' lawyers as expeditiously as possible.**

**Rationale:** To prevent any delays and controversy during the proceedings.

As I indicated in my discussion of the Inquiry Process, the fees and disbursements of the Participants' lawyers were not paid in a timely manner at the beginning of the Inquiry. These fees are usually heavily discounted in comparison with the fees normally charged by law firms to commercial clients (or in comparison with fees normally regarded as reasonable by the courts when assessing costs in civil proceedings). In addition, when a commission holds hearings in as remote a location as Elliot Lake, the disbursements borne and carried by the Participants' lawyers can be substantial.

To prevent any unnecessary delays and controversy during the proceedings, I recommend that, once the government agrees to provide funding to Participants at an inquiry following a recommendation to that effect by the Commissioner, it appoint its independent assessment officer and pay Participants' lawyers' accounts for fees and disbursements as expeditiously as possible.

**Recommendation 2.38**

**In imposing a deadline for the work of an inquiry, the Ministry of the Attorney General should consider a reasonable period for the set-up of the inquiry.**

**Rationale:** To ensure that the deadline is realistic and avoid requests for extension of time.

Although I fully recognize the right and responsibility of the government to impose a deadline on the work of an inquiry, such a deadline must be a realistic one, given the mandate and scope of work. It must also take into account all the "setting up" that needs to take place before the actual work can begin. As discussed, staff must be retained, offices located, computers rented. Competent and experienced counsel cannot simply drop everything to begin work instantly on an inquiry. Offices do not magically appear.

I would recommend, therefore, that any deadline imposed by the government include a reasonable period of set-up time and that the government ensure that its resources are in place to assist the inquiry in the basic organizational phase of its work. In the case of this Commission, I found the government was slow or ill-equipped to assist with essential prerequisites such as location of suitable office space, accounting services, and the securing of specialized resources.



## Summary of Recommendations

### Provincial organizations and capabilities

#### Recommendation 2.1

The capacity to respond to structural collapse emergencies should be increased in Ontario.

#### Recommendation 2.2

The provincial government and others should explore possible collaboration with Ontario Mine Rescue as a partial solution to ensure adequate province-wide capability to respond to structural collapses.

#### Recommendation 2.3

The province should initiate discussions to bring the medium urban search and rescue (USAR) teams that currently exist in Ottawa and Thunder Bay into the provincial inventory.

#### Recommendation 2.4

On request, the province should make incident support teams available to incident commanders.

#### Recommendation 2.5

The province should examine the model of a volunteer-based emergency response used by the German Federal Agency for Technical Relief (Technisches Hilfswerk, or THW) to determine if it could have any application in Ontario.

#### Recommendation 2.6

Statutory authority should give jurisdiction to a coroner to authorize entry to a building, by any safe means including demolition, for the purpose of retrieving a body.



### Incident Management System / chain of command

#### Recommendation 2.7

Whenever a municipal or provincial emergency is declared, its management should contain the following mandatory features, each of which is reduced to writing:

- a clear chain of command;
- defined responsibility and accountability for all in the chain of command;
- a clear and consistent line of communication for all responders;
- a plan of action determined by the individual in charge after consultation; and
- an early and comprehensive briefing of all team members before the plan is carried out.

#### Recommendation 2.8

There should be only one person in overall charge of a response; a “unified command” structure should be avoided.

#### Recommendation 2.9

The incident commander, the senior person in the chain of command, in a municipally declared emergency should be either

- (a) the person in charge of the initial agency that responds, unless and until that person delegates that authority in writing to another person; or
- (b) the person in charge of an agency determined by a matrix that assigns responsibility before an incident on the basis of the agency most closely linked to the type of emergency at issue.

#### Recommendation 2.10

The province should put in place strategies that will increase the acceptance and actual use of the Incident Management System (IMS) – including simplifying its language and instituting joint training and exercises – so as to be able to make it mandatory in the near future.



## Communications

### Recommendation 2.11

Provincial media and communications expertise should be made available, either as a stand-alone service or as part of incident support teams, to municipalities during declared emergencies or where provincial resources have been used.

### Recommendation 2.12

The Ontario government should make it mandatory to provide private space and regular updates to family members of victims on the progress of rescue and recovery operations during declared emergencies or where provincial resources have been used.

### Recommendation 2.13

Training for rescue and recovery operations should stress providing the public with timely and accurate information about casualties and the progress of a rescue operation (subject to legitimate operational requirements).

### Recommendation 2.14

Where multiple agencies are present at a rescue operation, they should have continuous access at the command level to common-frequency radios or communications equipment.

### Recommendation 2.15

Specialized rescue workers must be trained to accept the need for contemporaneous record-keeping during an emergency response. To facilitate the process, waterproof notebooks should be provided and consideration should be given to the acquisition of hands-free recording technology.



## HUSAR/TF3 (Heavy Urban Search and Rescue Task Force 3)

### Recommendation 2.16

HUSAR/TF3 should conduct debriefings in a timely fashion following any deployment.

### Recommendation 2.17

HUSAR/TF3 should create an after-action report in a timely fashion following any deployment. In the case of a provincial deployment, the after-action report should be submitted to the Office of the Fire Marshal and Emergency Management (OFMEM).

### Recommendation 2.18

HUSAR/TF3 and UCRT (the OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team) should enter into a memorandum of understanding with each other that clearly sets out the command structure under which they will operate when jointly deployed.

### Recommendation 2.19

HUSAR/TF3 should implement procedures to ensure that qualified section chiefs are available for deployment.

### Recommendation 2.20

HUSAR/TF3 should implement procedures to reduce or eliminate the unpredictability of the size of the team it is able to muster following a call-out.

### Recommendation 2.21

The HUSAR/TF3 site commander should be supplied with a scribe on all deployments.

### Recommendation 2.22

HUSAR/TF3 should ensure that it has access to qualified drivers to transport the cache of equipment on deployment.

### Recommendation 2.23

HUSAR/TF3 should explore additional sources for tractor rentals.

### Recommendation 2.24

HUSAR/TF3 team members should receive training for rigging operations.

### Recommendation 2.25

Standard operating procedure for HUSAR/TF3 should require fully documented incident planning, which is provided to supervisory personnel.

### Recommendation 2.26

HUSAR/TF3 should receive adequate funding to ensure that it is properly equipped and trained to respond to structural collapses in a timely manner with sufficient personnel and expertise. The Joint Emergency Preparedness Program (JEPP) funding should be reinstated by the federal government.



## UCRT (The OPP Urban Search and Rescue and Chemical, Biological, Radiological, Nuclear, and Explosive Response Team)

### Recommendation 2.27

The OPP should implement a duty roster requiring

- (a) a minimum number of commanding officers who can serve in the command structure of an emergency response and represent UCRT therein; and
- (b) a sufficient number of commanders who can lead UCRT forces on the ground and be available to respond in a deployment.



## Speed of response

### Recommendation 2.28

There should be more training of HUSAR/TF3 and UCRT members on the utility and capability of cranes in rescue operations.

### Recommendation 2.29

HUSAR/TF3 should send advance teams to a collapse site ahead of the full team.

### Recommendation 2.30

The OPP (and all initial first responders) should forward as soon as possible to the deployed rescue team any photographs that have been taken of an emergency.

### Recommendation 2.31

HUSAR/TF3 should mobilize and deploy with all practicable speed. Impediments to rapid deployment should be eliminated.



## Ministry of Labour

### Recommendation 2.32

Ontario should clarify the roles and responsibilities of Ministry of Labour inspectors and engineers at the scene of an ongoing rescue or recovery effort.

### Recommendation 2.33

The Ministry of Labour should use section 21 committees to further ensure that first responders are knowledgeable about the role and authority of the ministry and how it compares and contrasts with their own responsibilities during an emergency.



## Debriefings and after-action reports

### Recommendation 2.34

Timely debriefings and after-action reports should be mandatory for all agencies and organizations involved in rescue and recovery operations where an emergency has been declared or where provincial resources have been called in to assist. The after-action reports should be shared among all agencies involved.



## The Inquiry Process

### Recommendation 2.35

The Government of Ontario and other institutions identified in this Report should issue a public report within one year on their response to these recommendations and what steps, if any, they are taking to implement them.

### Recommendation 2.36

The Ministry of the Attorney General should prepare and keep current a tool-kit of policies and relevant documents for newly appointed commissioners and administrative staff.

### Recommendation 2.37

The Ministry of the Attorney General should appoint an independent assessment officer and pay the accounts of the Participants' lawyers as expeditiously as possible.

### Recommendation 2.38

In imposing a deadline for the work of an inquiry, the Ministry of the Attorney General should consider a reasonable period for the set-up of the inquiry.





## Notes

- <sup>1</sup> Ian Ross, "Mine Rescue considers search-and-rescue partnership," *Northern Ontario Business* (24 March 2014) online: Northern Ontario Business <www.northernontariobusiness.com>.
- <sup>2</sup> *Coroners Act*, RSO 1990, c 37, ss 16(1), 16(3), as amended by SO 2009, c 15, s 8.
- <sup>3</sup> *Coroners Act*, RSO 1990, c 37, s 16.1(1), as amended by SO 2009, c 15, s 8.
- <sup>4</sup> Comella testimony, September 4, 2013, p. 23924.
- <sup>5</sup> McRae testimony, September 25, 2013, pp. 27210–11.
- <sup>6</sup> Neadles testimony, September 10, 2013, pp. 25215–16.
- <sup>7</sup> Neadles testimony, September 11, 2013, pp. 25335–6.
- <sup>8</sup> Comella testimony, September 5, 2013, p. 24167.
- <sup>9</sup> Exhibit 887, p. 054.
- <sup>10</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, ss 1, 4(1).
- <sup>11</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 7.0.1(3), as amended by SO 2006, c 13, s 1(4).
- <sup>12</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 5.1(1), as amended by SO 2002, c 14, s 7, SO 2006, c 35, Schedule C, s 32(3).
- <sup>13</sup> Exhibit 887, p. 30.
- <sup>14</sup> Ronald Jenkins Transcript, December 5, 2013, p. 65.
- <sup>15</sup> Hefkey testimony, August 9, 2013, pp. 20438–9, 20472.
- <sup>16</sup> Comella testimony, September 4, 2013, pp. 24055–6.
- <sup>17</sup> Neadles testimony, September 11, 2013, p. 25462.
- <sup>18</sup> New York City Office of Emergency Management, *Planning & Response: Emergency Response*, online: <http://www.nyc.gov/html/oem/html/about/about.shtml>
- <sup>19</sup> deBortoli testimony, October 7, 2013, pp. 28467–8.
- <sup>20</sup> Benjamin Morgan, transcript, December 5, 2013, pp. 176–7.
- <sup>21</sup> Basia Schreuders, transcript, December 5, 2013, p. 183.
- <sup>22</sup> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9, s 5.1(1), as amended by SO 2002, c 14, s 7, SO 2006, c 35, Schedule C, s 32(3).
- <sup>23</sup> Exhibit 8109, p. 015; Officer testimony, August 22, 2013, pp. 21728–30, 21733–5; Officer testimony, September 19, 2013, p. 26409; Bruce testimony, August 23, 2013, pp. 22191–2; Exhibit 6336, p. 61.
- <sup>24</sup> Officer testimony, August 22, 2013, pp. 21868–9.
- <sup>25</sup> Chambers testimony, September 18, 2013, pp. 26070, 26103, 26139, 26144.
- <sup>26</sup> Exhibit 768.
- <sup>27</sup> Duerr testimony, August 15, 2013, p. 20836.
- <sup>28</sup> Coby Duerr transcript, December 5, 2013, p. 232.
- <sup>29</sup> Coby Duerr transcript, December 5, 2013, p. 142.
- <sup>30</sup> Gillespie testimony, September 3, 2013, pp. 23506–8.
- <sup>31</sup> Officer testimony, August 22, 2013, p. 21783.
- <sup>32</sup> Officer testimony, August 21, 2013, p. 21674.
- <sup>33</sup> Exhibit 7784, p. 015.
- <sup>34</sup> Neadles testimony, September 10, 2013, pp. 25264–5.
- <sup>35</sup> McCallion testimony, September 6, 2013, pp. 24478–9.
- <sup>36</sup> Comella testimony, September 4, 2013, p. 24079.
- <sup>37</sup> Selvers testimony, September 10, 2013, pp. 25112–13.
- <sup>38</sup> Selvers testimony, September 9, 2013, pp. 25011–12.
- <sup>39</sup> Needles testimony, September 10, 2013, pp. 25265–6.
- <sup>40</sup> McRae testimony, September 25, 2013, p. 27207.
- <sup>41</sup> Comella testimony, September 4, 2013, pp. 24061–2.
- <sup>42</sup> McRae testimony, September 25, 2013, p. 27196.
- <sup>43</sup> Gillespie testimony, September 3, 2013, pp. 23512–3.
- <sup>44</sup> Exhibit 9907.
- <sup>45</sup> *R v Port Colborne (City)*, [1992] OJ No. 2555 (Ont Ct J).
- <sup>46</sup> Exhibit 9907.
- <sup>47</sup> *Occupational Health and Safety Act*, RSO 1990, c O.1, ss 57(1), (6).
- <sup>48</sup> Exhibit 9907, p. 005.
- <sup>49</sup> *OPSEU Loc. 321 and Ministry of Labour (Re)* [1992] O.O.H.S.A.D. No. 9 at para 5.
- <sup>50</sup> *Toronto Computer Leasing Inquiry / Toronto External Contracts Inquiry, Volume 2: Good Government* (4 vols., Toronto, 2005), 139 (Commissioner Denise Bellamy).
- <sup>51</sup> Canada, Commission of Inquiry into the Decline of Sockeye Salmon in the Fraser River, *Final Report. The Uncertain Future of the Fraser River Sockeye; Volume 3, Recommendations – Summary – Process* (3 vols, Ottawa: Public Works and Government Services Canada, 2012), 67 (Commissioner Bruce I. Cohen).
- <sup>52</sup> British Columbia, Missing Women Commission of Inquiry, *Forsaken: The Report of the Missing Women Commission of Inquiry, Executive Summary* (Vancouver, B.C.: Missing Women Commission of Inquiry, November 2012), 159 (Commissioner Wally T. Oppal).
- <sup>53</sup> British Columbia, Ministry of Justice, *Safety and Security of Vulnerable Women in B.C., A Status Report in Response to: Forsaken: The Report of the Missing Women Commission of Inquiry* (Victoria: Ministry of Justice, 2013), 9.
- <sup>54</sup> *Public Inquiries Act*, 2009, SO 2009, c 33, Schedule 6.
- <sup>55</sup> Ontario, *Report of the Ipperwash Inquiry; Volume 3, Inquiry Process* (3 vols., Toronto: Ministry of the Attorney General, 2007), 63 (Commissioner Sidney B. Linden).
- <sup>56</sup> Ed Ratushny, *The Conduct of Public Inquiries: Law, policy, and practice* (Toronto: Irwin Law, 2009).

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# Inquiry Process

*I close by thanking the citizens of Elliot Lake.*

*Their personal and collective sacrifices are recognized throughout this Report. This community, at the official and individual levels, has made me and all other members of the Commission feel welcome, appreciated, and at home here in their beautiful and unique city. We will not forget them.*





## Inquiry Process

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## The purpose of this chapter

The creation of the Elliot Lake Commission of Inquiry and my appointment as Commissioner occurred on July 9, 2012, less than one month after the tragic events of June 23, 2012. Indeed, only six days after the collapse of the Mall, the then-premier of Ontario announced that an independent public inquiry would be held into the disaster, stating: “We have an obligation to do whatever we can to prevent similar tragedies and respond in the best way possible when they do happen.”<sup>1</sup>

The speed with which the Government of Ontario acted spoke, at least in part, to the importance it gave to those events for the people of Elliot Lake and for the citizens of this province, as well as to the need for change to ensure the safety of people who work in or frequent large buildings used for mercantile occupancy.

I have been a judge presiding over criminal trials for more than 36 years. Before my appointment as Commissioner, I had no experience with the conduct of such an undertaking. Nevertheless, it appeared to me that, while a criminal trial and a commission have different objectives and processes, their conduct shares many characteristics: they include the need for fairness, compassion, independence, careful and well-articulated reasoning, transparency and openness, expedition, efficiency, and effectiveness.

This part of my Report outlines the measures taken by the Commission to achieve the objectives set out in its mandate<sup>2</sup> with those characteristics in mind.

Mr. Justice Sidney Linden, in his *Report of the Ipperwash Inquiry*, usefully contrasts the differences between public inquiries and other proceedings:

### 1.3 Differences between Public Inquiries and Other Proceedings

Public inquiries are established by government, and their objective is to fulfill the mandate set out in an order-in-council, yet they are independent of government. Their role is also distinct from that of the legislative, executive, or judicial branches. Mr. Justice Cory of the Supreme Court of Canada pointed out that public inquiries, as temporary bodies, “are free of many of the institutional impediments, which at times constrain the operation of various branches of government.” He further wrote that

[i]nquiries are, like the judiciary, independent; unlike the judiciary, they are often endowed with wide-ranging investigative powers. In following their mandates, commissions of inquiry are, ideally free of partisan loyalties and better able than Parliament or the legislatures to take a long-term view of the problem presented.

Despite these institutional distinctions, those observing a public inquiry and indeed even those directly participating in one, often assume that it is like a trial. This is understandable. Although the specific features of inquiries vary, often the commissioner is a judge, the hearings are usually held in a court-like environment, and evidence is obtained from witnesses who may be examined and cross-examined by lawyers. In the case of the Ipperwash Inquiry, for example, I had powers to summons witnesses to attend, and if necessary to produce documents, and to make findings of misconduct in my report. However, a public inquiry is not a trial, and, generally, a commission is not established to revisit judgments already passed. While a commission may establish wrongdoing or misconduct, it does not find anyone guilty of a crime, nor does it establish civil liability for monetary damages. To underscore this point, I described these limits in my public statements during the Inquiry.

Unlike a civil or criminal trial, a public inquiry is more inquisitorial than adversarial, in that the objective of those involved in the process is to uncover the truth rather than to establish liability. Nevertheless, the proceedings can become heated at times. Invariably, a public inquiry involves groups, individuals, or institutions with legitimate and often competing interests that must be explored. And, although an inquiry is not intended to determine guilt or innocence, or fault or no fault, the actions of individuals or institutions may be questioned and misconduct may be found. This, and the fact that the investigation is conducted in public, carries with it the possibility that individual or organizational reputations will be at



risk. Counsel have a duty to protect and/or advance their clients' interests, and therefore an adversarial element invariably makes its way into the inquisitorial process. Given this reality, it is imperative that the inquiry process include safeguards that uphold the principles of natural justice and procedural fairness. Inquiries with both fact-finding and policy mandates also face the challenge of accommodating the sometimes competing interests of lawyers and policy-makers. Lawyers retained by an organization or individual directly involved with or affected by the subject of the investigation are likely to focus only on the interests of their clients. They will therefore support procedural arrangements that afford maximum protection of their clients' legal rights. On the other hand, policy-makers, and lawyers representing parties with a broader policy focus, are likely to seek the broadest possible body of information relevant to the policy debate. They will tend to resist procedural mechanisms that may narrow the scope of the inquiry. The challenge is to put in place procedural and organizational structures that satisfy both fairness in fact-finding and thoroughness in eliciting information to contribute to the policy debate.

Another feature that distinguishes public inquiries from trials is that public inquiries are not strictly bound by the rules of evidence that govern civil or criminal proceedings. Our Rules of Procedure and Practice (the "Rules") stated that "[t]he strict rules of evidence will not apply to determine the admissibility of evidence." The commissioner of a public inquiry may receive any relevant evidence including evidence that might be inadmissible in a court of law, such as hearsay evidence. However, although hearsay evidence may be admitted at a public inquiry, the commissioner may accord little weight to it.<sup>3</sup>

## The purposes of this Commission of Inquiry

The Order in Council creating this Commission asked me to:

- Inquire into the events surrounding the collapse of the Algo Centre Mall in Elliot Lake on June 23, 2012.
- Inquire into the emergency management and response subsequent to the collapse.
- Review the existing legislation, regulations, by-laws, policies, processes and procedures relating to the first two subjects of the inquiry.
- Report my findings, conclusions and recommendations to the Attorney General.\*

Therefore, this Inquiry has both retrospective and prospective functions as I outlined in more detail in the first chapter of Part I of the Report. It is to look back to discover the causes of the collapse and to examine the conduct of the rescue / recovery effort. But it is also to look forward and to make recommendations, both to prevent a recurrence and to improve the emergency management process.

Clearly, the principal objectives of the Inquiry are not blame, retribution, or attribution of liability or culpability; this Commission exists to discover what went wrong and to suggest measures that will make Ontario a safer place.

## The public nature of a commission of inquiry

As Mr. Justice Linden pointed out:

In my view, what distinguishes the public inquiry from other types of investigations is that it is truly *public*. It investigates a matter of public interest, in public view, and with the participation of the public. This attribute was at the heart of all my decisions affecting the inquiry process.<sup>4</sup> [Emphasis in original.]

• • • • •

\* Order in Council OC 1097/2012 and Order in Council OC 1873/2013 (amended), reproduced as Appendix F and Appendix G.

I agree entirely. Confidence in the work of a commission such as mine depends, in large part, on the public's understanding of, and substantial agreement with, its means, methods and objectives.

At the hearing I held dealing with claims for confidentiality, I said:

[W]henever a conflict arises between the expectation of privacy or confidentiality and the open court principle, "jurisprudence has now unquestionably and conclusively established that, as between these two values, the onus of demonstrating primacy in any particular circumstance rests on those who would restrict full and unalloyed publicity and transparency."<sup>\*</sup>

That was invariably my guiding principle.

There will be exceptions, of course. For example, notices under s. 17 of the *Public Inquiries Act*<sup>5</sup> requiring that persons be provided with reasonable notice of a potential finding of misconduct are kept strictly confidential because, after hearing the evidence, such a finding may eventually not be made and publicity might negatively affect reputations.

In addition, I issued a non-publication order of certain graphic and potentially disturbing photographs.

Access to all of the material obtained in response to the Commission's summonses was only permitted to Participants upon the execution of confidentiality undertakings, because only a small portion of that massive database would be relevant and made exhibits. The remainder would not be relied on by the Commission and could contain private information.

Finally, I ordered redaction or non-publication of some non-relevant private information found in some exhibits – personal social insurance numbers, for example – for obvious reasons.

## My first contact with the community of Elliot Lake

At the time of my appointment, I had a very limited knowledge of the geography, demographics, and history of this part of our very large province. By virtue of the relative isolation of the City of Elliot Lake and its comparatively small size, recruitment of Commission counsel and administrative / support staff had, of necessity, to come from a larger centre. Ottawa was the city I was most familiar with and my choices were, for the most part, confined to that city.

Consequently, I was conscious of, and determined to dispel as much as possible, the perception that we "the big city folks" would descend on Elliot Lake and impress the local citizenry with our wisdom and talent. To that end, one of my first decisions<sup>1</sup> was to come to Elliot Lake with senior counsel and staff to formally introduce ourselves and to answer questions from the public and media. Most significantly, we came to hear from the residents about the impact of the tragedy on their lives and on the community as a whole. I wrote an open letter and sent a televised message to them to that effect.<sup>2</sup>

On August 15, 2012, I travelled with my senior staff to Elliot Lake to meet with residents, both publicly (at a meeting of the community held at the Lester B. Pearson Community Centre) and privately.<sup>3</sup> We also toured the site of the collapse and counsel met with members of the Chamber of Commerce, the Fire Department, the

.....

<sup>\*</sup> Ruling on Confidentiality, January 8, 2013, p. 2, Appendix M.2.

<sup>†</sup> Upon the wise advice of previous commissioners, such as Associate Chief Justice (as he then was) Dennis O'Connor and Justice Stephen Goudge of the Ontario Court of Appeal.

<sup>‡</sup> See Commissioner Bélanger's statement to residents of Elliot Lake, August 1, 2012, Appendix J.1.

<sup>§</sup> See Address of Commissioner Bélanger to the residents of Elliot Lake, Appendix J.2.

Ontario Provincial Police, and elected officials. We also met with the families of the two victims. In total, we heard from approximately 40 individuals, many of whom preferred to speak to us in a private setting about their grief, losses, and trauma. As I reported later:

[W]e all left with a clear understanding of how emotional the issues we are investigating are to this community, and the absolutely devastating impact the collapse of the Algo Centre Mall has had on the people of Elliot Lake and surrounding community. As we continue our work, we will most certainly keep these sentiments in mind and remember the two citizens who perished in this tragedy.<sup>6</sup>

Our entire three-day stay was well publicized and well attended and we returned to Ottawa somewhat confident that we had successfully broken the ice.

## Particular challenges

### Geography

Every inquiry faces unique challenges – for example, national security or scientific complexity.

For this Inquiry, one of the key challenges was clearly geographic. I determined early on that it was critical that the public hearings be held in Elliot Lake. Many of the witnesses would be local, of course, but in addition to

**Because virtually all the citizens of Elliot Lake had, in one way or another, undergone the consequences of the collapse, the Commission's physical presence in the community might be both cathartic and restorative.**

the functional and practical reasons for local hearings, I felt that there were other compelling reasons. Because virtually all the citizens of Elliot Lake had, in one way or another, undergone the consequences of the collapse, the Commission's physical presence in the community might be both cathartic and restorative. It went beyond mere symbolism. The Commission was, in a real sense, *their* commission. Without a doubt, thanks to modern technology all the proceedings could have occurred at a distance, but nothing compares to experiencing the reality of a witness being questioned in a live setting. In any event, since most of the Participants' lawyers lived outside Elliot Lake, travel (and its attendant costs) would be necessary, regardless of location.

Elliot Lake is about 650 kilometres by road to Ottawa, a trip of approximately eight hours by automobile. It was clear from the outset that we would have to secure long-term accommodation for me, counsel, and staff. One of the city's two hotels was under the rubble of the Algo Mall and the other, of necessity, was not only almost fully booked but would also be more expensive compared with the cost of leasing private residences or apartments. Fortunately, these accommodations were in relatively plentiful supply and a sufficient number were rented for the duration of the hearings.

A substantial number of the many witness interviews Commission counsel conducted to prepare for the formal hearings had to be held outside Ottawa. To the extent possible, many interviews were conducted by telephone.

Although the City of Elliot Lake operates its municipal airport year-round, it is not served by the large commercial carriers. The closest airports served by commercial airlines are in Sudbury or Sault Ste. Marie, a two hour-drive in ideal conditions. The rigours of winter and near-winter conditions in Northern Ontario often made driving or flying on commercial airlines difficult, if not occasionally impossible; this situation created budgetary difficulties because of problems such as missed or rescheduled witness interviews or counsel marooned in airports when flying conditions worsened.



The Elliot Lake airport has a good landing strip that can accommodate private or charter aircraft. A cost-benefit analysis made clear that hiring a charter aircraft would be ideal to give my staff a trip to Ottawa every second week to attend to personal affairs and family, ensuring very rapid cost-effective transportation with no time-consuming large airport procedures and attendant delays. The flight time between the two cities is only one hour and 20 minutes on average, allowing for arrivals in Ottawa in the early evening on Thursdays and return to Elliot Lake in the early evening on Mondays. I preferred to remain in Elliot Lake most weekends.

## Hearing facilities

The Commission also required suitable premises in which to conduct the hearings. Fortuitously, one building was centrally located in the city and available for retrofit. The White Mountain Academy of the Arts, in disuse since 2006 as an academic institution, was already occupied to temporarily accommodate municipal, provincial, and local services that had been located in the Algo Mall. The building was beautiful, airy, and solidly constructed, having been designed to house the CANMET Laboratory when the uranium mines were in operation. With the assistance of the municipality and the Province of Ontario, a hearing room was designed and constructed on the second floor, along with attendant facilities such as press room, Commission offices and conference room, witness interview rooms, and public viewing room. It served admirably well for the duration of the hearings.

The hearing room itself would be the envy of any commission or, indeed, any tribunal. Counsel tables for 25 were equipped with microphones, electrical and computer connections, and document viewer / repeaters. Four large-screen monitors were strategically located throughout the room so that the public in attendance could view documents on screen. Remotely operated cameras captured the scene and the players as witnesses were examined, as counsel addressed me, and as I did my work. A large electronic interactive whiteboard was available for all to view paper documents and to allow witnesses to mark graphic / photographic evidence and make their markings part of the exhibit record. The Commissioner's elevated dais allowed for a panoramic view of the entire room and was equipped with three monitors, showing documentary evidence, the simultaneously produced transcript, and the examiner / witness. Sound amplification was provided. Proceedings were remotely telecast within the building to a café room on the ground level so that the public could follow proceedings in a more relaxed atmosphere. The proceedings were also fed to monitors in the press room so that journalists could work outside the hearing room.



Figure 2.12.1 The hearing room

Benches for public seating accommodated approximately 50 persons and were always sufficient for our purposes. An elevated control booth in one strategically located corner allowed the on-site technician to survey the proceedings and to constantly adjust the cameras, microphones, and other equipment to provide continuous uninterrupted coverage.

Inquiry Services, a subsidiary of Avolution Multimedia, was responsible for the design, installation, and operation of the audio visual coverage system, press pool, and broadcast feeds and the evidence display system. This firm had provided similar systems to the Ipperwash, Pediatric Forensic Pathology, and Cornwall inquiries. Its level of service and expertise was exceptional.

## Ottawa Commission offices

Until I, some staff, and counsel could move to Elliot Lake for the hearings, suitable office space had to be found in Ottawa. The Government of Ontario justifiably expressed a preference that the Commission use existing government assets for that purpose. Unfortunately, none existed in July and August 2012 that could accommodate my full staff for the entirety of the Commission. Leased premises were found on Blair Road pending refurbishment of facilities in the industrial park section of St. Laurent Boulevard. The Commission was on Blair Road from August 2012 until March 2013, and Ottawa-based staff moved to the St. Laurent property owned by the Province of Ontario in March 2013. Staff, counsel, and I returned there from Elliot Lake in October 2013 and remained there until the completion of our work.

## Translation and interpretation

Elliot Lake has a significant French-language-speaking population, as does all of Northern Ontario. It was apparent to me from the outset that all my public proceedings would have to be simultaneously translated into one or the other official language and that all the Commission's official documents would have to be produced in both. To that end, a soundproof translation booth was installed in the hearing room, and certified interpreters were hired to provide simultaneous translation of all the proceedings throughout the eight months of the hearings.

## Other proceedings

The Order in Council creating the Commission stipulated that the "Commission shall further ensure that the conduct of the inquiry does not in any way interfere or conflict with any ongoing investigation or proceeding related to these matters." In that respect, care had to be exercised not to interfere with an ongoing criminal investigation by the Ontario Provincial Police, civil proceedings, a Ministry of Labour investigation, and a potential coroner's inquest. Fortunately, no insurmountable issues arose during the conduct of the Inquiry by virtue of the existence of parallel proceedings. Indeed, Robert Wood, who had standing at this Inquiry, was charged on April 22, 2013, under the *Occupational Health and Safety Act*, and on January 31, 2014, under the *Criminal Code*, but continued to be a full participant in the Commission's proceedings.

As I describe further below, the criminal charges led to Mr. Wood's application before me in May 2014 for an order that my report be redacted before being publicly released to remove "only passages that deal with the matter of the Applicant's Section 17 notice."

## Technology

One of the challenges that the Commission faced from its inception was the set-up of its information technology network as well as its ability to access the Internet in Elliot Lake. Although the information technology section of the Ministry of the Attorney General offered to set up the necessary informatics system, the Commission felt that the Government of Ontario's protocols and policies would limit the remote and flexible access it required for counsel and staff and opted to set up its own independent, efficient, and reliable system. The main challenge for the Commission was obtaining sufficient bandwidth to ensure the live broadcasting of the hearings from Elliot Lake as well as remote access to the large volume of data located on its server in Ottawa. These difficulties were eventually resolved, but not without substantial delays and painful hurdles for the Commission staff.

## The *Public Inquiries Act*, 2009

This Commission was the first public inquiry conducted in Ontario since the enactment of the *Public Inquiries Act*, 2009.<sup>7</sup> Before then, the authorizing statute was the *Public Inquiries Act*.<sup>8</sup> This legislation made important and significant changes to the framework governing the administration of public inquiries, including:

- the authority granted to government to fix the date for the delivery of the commission's report (section 20(1));
- the authority granted to government to set a budget for the conduct of the inquiry (section 25 (1)) and the obligation of the commission to be financially responsible and to operate within budget; and
- the obligation to share with the government administrative information relating to budget, actual and projected expenditures, timing and progress of the inquiry, and production and delivery of the report (section 27(1)).

The financial obligations set out under the new legislation required the hiring of a financial analyst who would be an employee of the Government of Ontario and who would have access to the government's financial system. While the selection process was in progress, the setting up of the financial system for the Commission and the preparation of the initial budget forecast was done through the Ministry of the Attorney General in Toronto. This process was time-consuming and resulted in many delays in processing invoices during the first few months. Nevertheless, these comments should not be construed as being critical. The Commission recognized and agreed with its obligation to be effective, expeditious, and financially responsible. Throughout the duration of the Inquiry, the Commission had complete access to and assistance from various departmental personnel while respecting the delicate balance between the principle of independence and the government's obligation to be a prudent steward of public funds. This co-operation was particularly evident during the administrative process required when requesting any extension to the Commission's mandate. At no time was I given cause to fear interference of any sort with the Commission's independence.



## The initial stages

### Staffing

Finding and recruiting staff and counsel was my initial preoccupation after my appointment. As other commissioners have pointed out, the limited term of a commission makes recruitment of experienced and qualified staff and lawyers problematic. For administrative staff, secondment is an option that is not career limiting and, to the extent possible, I resorted to that method.

Identifying an experienced executive director could have been another matter, but I was most fortuitously blessed by discovering that Suzanne Labbé (see acknowledgments, below) was just then ending her term as executive director of the 2011–12 federal Judicial Compensation and Benefits Commission.

I was also successful in quite quickly recruiting my first choice of counsel. The role of Commission counsel is to assist the Commissioner in carrying out the Commission's mandate. This role was aptly described by one of my Commission counsel at the opening of the hearings:

[T]he role of your counsel is to assist you with your obligation to find the facts that led to the tragedy that occurred on the 23rd of June of last year and the response to that tragedy.

Unlike the normal situation for us, your counsel, when we are in court, our duty is not to advance or defend the interest of any particular party. Our brief is to determine the truth, whatever that may be.<sup>9</sup>

As described by Associate Chief Justice (as he then was) Dennis O'Connor, commission counsel becomes the alter ego of the commissioner.<sup>10</sup> Aside from being advocates in the hearing room, Commission counsel were the liaison between me and the Participants and witnesses, ensuring that the hearing ran smoothly and expeditiously but without compromising thoroughness and diligence.

### Process stages

It was immediately apparent that there would be three distinct parts to the mandate of the Commission. First, it was necessary to conduct an analysis of the causes of the collapse. Second, I would have to review the emergency response following the collapse. And, finally, I would need to formulate my recommendations. Different mixes of players would necessarily be involved in each area. The first two portions would be essentially fact-finding: evidentiary and analytical. The third segment would be policy oriented and would depend on my conclusions drawn from the evidentiary experience, aided by suggestions from Participants and experts. Consequently, Part One of the hearings in Elliot Lake concentrated on the history of the Algo Mall from its conception until its eventual destruction after the collapse. Part Two of the Elliot Lake hearings dealt with the facts surrounding the emergency response. The third area consisted of roundtables of experts in Ottawa dealing with discrete subjects emanating from my examination of the factual material, with a view to crafting realistic recommendations. The three areas proceeded sequentially.

### Preliminary investigation and summonses

Even before the Commission had formal offices, my staff conducted some preliminary investigations to assess who possessed documents relevant to the Commission's mandate and to identify potential witnesses.

A review of media coverage of the collapse allowed the Commission to prepare a tentative chronology of events, as well as prepare a list of potentially relevant individuals and corporations. But more importantly, this review led the Commission to issue, at the end of August 2012, less than two months after its creation, its first series of summonses for production of documents. This first series of summonses was directed to municipal and provincial

government departments and agencies (Ministry of Labour, Ministry of Community Safety and Correctional Services, Ontario Provincial Police (OPP), City of Elliot Lake, City of Elliot Lake Fire Department, Toronto Police Services, City of Toronto).

In September 2012, following a title search of the Mall ownership records, the Commission issued a second series of summonses to a variety of individuals and corporations, including the current owner of the Mall, Eastwood Mall Inc.; as well as the two previous owners, Algoma Central Properties Inc., and 1425164 Ontario Limited (known as NorDev); and builders, architects, engineers, consultants, tenants, insurers, and bankers.

The Commission continued to issue summonses for production of documents throughout its proceedings to a variety of individuals and organizations as the review and analysis of documents continued and led the Commission to new investigation leads. Post-collapse investigations conducted by bodies such as the OPP and the engineering specialists it retained were a major source of materials for the Commission. In total, more than 120 summonses for production were issued by the Commission, resulting in more than 550,000 documents, amounting to more than a million pages.\*

## Request for information

In some cases, the summonses issued by the Commission required production of information in addition to documents. Indeed, paragraph 10(1) of the *Public Inquiries Act, 2009*, provides that a commission may serve a summons requiring a person to “produce for the public inquiry any information, document or thing under the person’s power or control.” That was the case, for example, for the Ministries of Labour and Community Safety and Correctional Services, the OPP, and the City of Elliot Lake. Generally, these summonses required them to provide an outline of the policies, processes, and procedures of the various ministries or agencies with respect to emergency management. What was contemplated was the preparation of an analysis by those possessing the most intimate knowledge of these topics, and not merely the production of promulgated policies and manuals. The analysis would explain the overall process, pulling together and elaborating on the documents produced. The Commission recognized that those who deal with the subject matter on a daily basis possessed the expertise and depth of knowledge necessary to provide this form of commentary and thus contribute to the successful completion of the Commission’s mandate.

By making this type of request, it was the intention of the Commission to use this information produced in accordance with subparagraph 9(1)(f) of the *Public Inquiries Act, 2009*.<sup>†</sup> This was a new feature of the newly enacted legislation designed to ensure efficiency and cost effectiveness in public inquiries.

## Interviews by investigators

To assist the Commission in its duties during its initial stages, I retained on secondment two experienced Ottawa police investigators who aided Commission counsel and me in locating witnesses and conducting preliminary interviews. Their assistance was particularly valuable in locating individuals who were involved in the events surrounding the construction of the Mall in the late 1970s and during its first years of operations.

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\* An example of the Commission’s Summons to Produce Documents appears as Appendix N.

† Subparagraph 9(1)(f) provides that a commission shall, as much as practicable and appropriate, refer to and rely on any other document or information, if referral to and reliance on the document or information would promote the efficient and expeditious conduct of the public inquiry.

## Documents

When Commission counsel first met with the OPP in August 2012, they were advised that the volume of documents that the OPP had collected – which would undoubtedly be relevant to the mandate of the Commission and eventually produced to it pursuant to a summons – was in excess of one terabyte of electronic material: a daunting quantity, to say the least.

Nevertheless, it came as no surprise that the volume of documents that the Commission needed to gather would be very large. The Algo Mall had existed for 33 years, and we anticipated that the records generated during that time would come from a multitude of sources. Furthermore, it was fully expected that the Internet and email traffic would increase the number of documentary records exponentially, if not qualitatively. Although the aftermath of the collapse occupied a much more limited period, the amount of data generated was similarly voluminous. As a result, I felt it was impossible to conduct the initial investigation in a timely way without the assistance of a document management firm as well as a document review firm.

Inquiring into events surrounding the construction of the Mall concerned the Commission because of the structure's age and the passage of time. Indeed, we discovered early on that several key figures from that time period had passed away. However, the Commission was fortunate that its first owner, and the one that initiated its construction, Algoma Central Properties, still possessed a file on its construction and operation. This file was provided to the Commission pursuant to a summons.

### Electronic document management and review services

The Commission retained the services of esi Specialists, a Toronto firm with expertise in collection, identification, capture, review, and production of all forms of digital evidence as well as the creation of a data and web-hosting platform for online discovery and review.

The Commission's documents were hosted in a database called Relativity. Relativity served not only as the repository for all the documents received by the Commission, but also as the tool used by Commission, Participants', and witnesses' counsel to review and analyze documents throughout the proceedings. Relativity is a web-based platform that lets its users conduct advanced searches. Because it is intuitive, it allowed the Commission to search, review, and digest documents quickly and efficiently.

Early on, we decided to aim to keep paper documents to a minimum and, therefore, have as paperless a hearing as possible.

The Commission retained the services of the law firm of Wortzman Nickle to assist in the culling and triage of the many gigabytes of materials in order to identify and exclude non-relevant documents. Commission counsel met with the Wortzman Nickle team to provide it with an overview of the issues and themes that were likely to become relevant to the Commission's mandate. This collaborative and coordinated effort resulted in a significantly reduced and manageable number of documents for Commission counsel to review.

After the documents were sorted and entered into Relativity by esi Specialists, they went through a first-level review by the Wortzman Nickle team. Wortzman Nickle was able to assemble a team of more than 20 lawyers in short order to assist us with the preliminary review of the documents.

In addition to identifying relevant documents, Wortzman Nickle assisted the Commission by, among other things, coding relevant documents to a series of issues identified by Commission counsel and identifying technical documents.



The Commission's document management clerk, Kassandra Kuka, ably oversaw the liaison between the Commission and esi Specialists as well as the various custodians. As the hearings began in Elliot Lake, her role was transformed into that of court operator managing the production of documents on large and small screens and electronic whiteboards in a seamless fashion.

### **Review of documents by Commission counsel**

Documents identified by the Wortzman Nickle team as potentially relevant then proceeded to a second review by Commission counsel. During this second review, Commission counsel confirmed the relevance of documents, where appropriate, but also identified key documents which eventually were entered as the first series of exhibits for both phases of the hearings or led to the creation of documents that were entered as exhibits. Because they identified important documents at the outset, these exhibits proved to be helpful tools for the Participants, who did not have to search among the many thousands of documents available to them. As it turned out, these were the exhibits most often referred to during the proceedings. For Part One, these first exhibits included a list of relevant individuals, consultants' reports, and engineering and architectural plans. For Part Two, these first exhibits included a list of key players, various policies and procedures, and photographs.

Although all these documents were admitted as evidence on a provisional basis, they were subject to being expunged from the record if a Participant's objection, filed within 21 days of admission, was upheld. The same procedure was applied to the documents appended to the Overview Reports, further discussed below.<sup>11</sup>

I note in passing that the Commission did make use of electronic keyword searches when possible in an attempt to reduce the volume of documents that would then proceed to first level review and the subsequent review by Commission counsel. These searches were particularly helpful with respect to the computers seized by the OPP, described below, as well as the data provided by the City of Elliot Lake.

### **Delay in production of documents by the Ontario government**

As I described above, the first summonses issued by the Commission, in August 2012, were directed at the various departments and agencies of the Ontario government. Commission counsel met with counsel for the Ontario government in September 2012 to discuss the issue of the production of documents. The Ontario government advised the Commission that it did not believe that it could produce the documents requested for approximately two months, until sometime in November 2012. Commission counsel advised that this was unacceptable, and that the production of documents in a timely manner was essential if the Commission was to meet its deadlines.

This was the beginning of what turned out to be a dilatory and fragmented response by the Ontario government to Commission summonses. By November 29, 2012, three months after the issuance of the summonses, the Commission had received only 636 documents from the Ministry of Labour and 3,426 documents from the Ministry of Community Safety and Correctional Services and its agencies. These numbers increased exponentially over the course of the subsequent months. A total of 9,097 documents were eventually received from the Ministry of Labour and 16,335 from the Ministry of Community Safety and Correctional Services and its agencies.

A total of 2,553 documents were eventually received from the Cabinet Office. It was later discovered, during the interview of one witness who worked in the Office of the Premier, that he had in his possession more emails which were not captured by the search conducted by the Ontario representative. These emails were added to the Commission's database in August 2013.

A dispute arose early on between the Commission and the OPP over production of documents in the possession of the OPP. The OPP initially took the position that, before providing documents to the Commission, it would be required to review every document to determine whether public disclosure would interfere with its ongoing investigation. The OPP advised that this process would take months. This situation created important difficulties for the Commission because it was apparent that, in a number of cases, documents were provided to the OPP as a result of a search warrant without copies being kept by their custodian. When summonses were issued by the Commission to those persons, they were unable to provide the documents sought. As a result, the OPP was in sole possession of vital information needed by the Commission to carry out its mandate.

Following discussions with the OPP, on October 3, 2012, it was agreed that the OPP would deliver to the Commission, as soon as possible, all documents described in the summons without a prior review.

By November 29, 2012, the Commission had received from the OPP 21,647 documents along with five hard drives containing forensic-quality copies of computer-related exhibits obtained by the OPP pursuant to the execution of search warrants (at, among other places, the residence and business of Bob Nazarian and the offices of M.R. Wright & Associates). The Commission would see this amount triple over the next few months. Indeed, on February 4, 2013, alone, the Commission received more than 29,000 documents from the OPP. A total of 73,245 documents were produced by the OPP (excluding the content of the hard drives, which exceeded 180,000 documents).

### **Late production of documents**

Production of summonsed material, which was initially voluminous, continued throughout the hearing phase. Indeed, in late September 2013, when the evidentiary hearings were nearly complete, the Commission received more than 19,000 emails from the OPP, which it had obtained, under the Mutual Legal Assistance Treaty, from GoDaddy, the US Internet-hosting provider for the Nazarians' email accounts. The Commission used a focused approach in conducting specific keyword searches of these documents, which produced only about 450 potentially relevant documents. Following a review, 29 were found to be marginally relevant to the Commission's mandate. In the end, it was determined that they did not constitute new evidence, required no further investigation, and did not warrant being made exhibits. Although they were not considered by the Commissioner in the preparation of this Report, these documents were brought to the attention of the Participants to preserve the transparency and openness of the public inquiry.

### **Production of documents by the Nazarians**

During the course of the proceedings, a dispute developed between the Commission and the current owner of the Mall over the provision of records.

In September 2012, I issued summonses to Bob Nazarian, Irene Nazarian, and Levon Nazarian to produce documents to the Commission.

By November 2012, the Commission had received only one banker's box of documents and one CD containing electronic documents in response to the summonses issued to the Nazarians. As a result, and given the conflicting information from the Nazarians' lawyers regarding the amount of documents in possession of their client, I issued summonses to their lawyers personally. These summonses resulted in few documents being produced.

In October and November 2012, the Commission reviewed the computers that the OPP had seized at the residence and business of Bob Nazarian and found very few emails among them. As a result, the Commission hired a forensic investigation firm (TCS Forensics Ltd.) to conduct a forensic investigation of the various hard drives and identify (1) whether there had been any deletions after June 23, 2012; (2) if any software had been used that would inhibit the forensic analysis (e.g., wiping software); and (3) any access to remote email / webmail and associated accounts. The forensic firm did not find any suspicious file deletion. It did, however, identify more than 4,500 emails relating to certain email accounts (including webmail accounts) used by Bob, Irene, and Levon Nazarian. Following further forensic analysis, the TCS concluded that there was no evidence of improper methods being used to securely remove data. The firm was able to recover and reconstruct images showing the webmail accounts. A preliminary review of the 4,500-plus emails as well as the recovered webmail pages disclosed evidence that the Nazarians were using these accounts as part of their management of the Mall. The forensic investigation also identified several smartphones that the Nazarians used.

As a result of the forensic analysis, in December 2012, I issued three additional summonses to the Nazarians for email accounts and smartphone devices discovered by the forensic investigation firm.

By February 4, 2013, a month before the beginning of the hearings, I had yet to receive any additional documents from the current owners. I therefore issued an order pursuant to section 29 of the *Public Inquiries Act, 2009*, requiring the Nazarians to comply with the summons. As I stated in my reasons for making that order:

Having applied for and obtained standing at this inquiry, it is incumbent upon Bob and Levon to comply with the summonses issued to them. In the Additional Summonses and subsequent correspondence, the Commission identified a series of email accounts that are in the possession, power or control of Bob and Levon. Despite numerous requests, Bob and Levon have not produced the emails relating to the Algo Centre Mall from those email accounts. Nor have they produced any evidence to the Commission to confirm that the requests for emails from third party service providers have even been made. Instead, throughout the documentary production process, they have shown disregard for the timelines set out in the summonses that I have issued, the reasonable requests of Commission Counsel, and now, my order of February 4, 2013. They appear to be of the view that they can produce what they want, when they want.\*

In March 2013, I retained counsel to state a case to the Divisional Court under section 30 of the *Public Inquiries Act, 2009*, the contempt provisions. On March 7, 2013, the Notice of Application for a stated case was issued by the Divisional Court, which assigned a hearing date of March 20, 2013.<sup>†</sup>

On March 8, 2013, the Nazarians turned over approximately 85,000 emails to the Commission. They also provided financial information sought in the summons. Each of the Nazarians also provided a sworn affidavit that set out in detail the steps taken by them to comply with the summonses and a signed direction to the Canada Revenue Agency directing it to provide income tax information to the Commission.

On March 19, 2013, I indicated that, in light of the provision of this information, I had instructed my counsel to discontinue the Divisional Court case.<sup>‡</sup>

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\* See Reasons for Decision and Stated Case, March 6, 2013, Appendix M.3.

† Statement by Commissioner, March 19, 2013, pp. 1734–5, Appendix J.6.

‡ Statement by Commissioner, March 19, 2013, p. 1737, Appendix J.6.



The emails provided by the Nazarians were not all relevant to the Commission's mandate. They were reviewed electronically, with keyword searches, in order to identify potentially relevant emails. The identified emails then proceeded to a first-level review by Wortzman Nickle's team and a subsequent review by Commission counsel. The first-level review also screened out any document that was potentially privileged. These potentially privileged documents were provided to the Nazarians' counsel for review to determine whether a claim of privilege would be asserted. Counsel for the Nazarians was then provided with an opportunity to assert a privilege claim within seven days of receipt of the emails in accordance with the provisions of Rule 11 of the Commission's Rules of Procedure.

## Access to database by Participants

I decided early on that all Participants with standing would be given access to all relevant material collected during the Commission's investigation, not simply those documents which were to be filed as exhibits. As a result, in December 2012, counsel for the Participants were advised that they would be given access in January to the Commission's database, Relativity, which contained all the relevant documents that the Commission had collected. They were required to sign an undertaking to keep the material confidential until it was made public at the Inquiry.\*

On January 16, 17, and 24, 2013, three training sessions on the use of Relativity were offered to Participants' counsel and representatives who, following the sessions, were provided access to the database via a password. Participants were required to pay a licence fee for their use of Relativity. Access to the database was not limited to Participants; it was also provided to counsel for witnesses who sought access. Participants were given access to the database in Relativity until the end of October 2013.

Throughout the proceedings, the Participants benefited from the assistance of Yvette and Steve Bula – initially of esi Specialists and later with SVR Litigation Case Management – for any technical difficulties, as well as guidance from Ms. Kuka, who mastered the use of Relativity.

## Witnesses

### Interview of witnesses by Commission counsel

Based on their review of the documents, and the investigators' preliminary interviews, Commission counsel identified the potential witnesses who would be called to appear before the Commission. Commission counsel conducted interviews of these witnesses in the presence of counsel, where they were represented.

Before each interview, the witnesses were provided with a brief of documents anticipated to be relevant to their evidence. Following each interview, a summary of the anticipated evidence of the witness (will-say statement) was prepared and provided to the witness for her or his review. These will-say statements were then distributed to the Participants before the witness's testimony (see Rules of Procedure section, below, with respect to the use of these will-say statements), along with a list of the documents related to the evidence of the witness to be entered as exhibits.

Witnesses were not compelled to attend these interviews, but nearly all readily obliged and co-operated with the Commission. There were only three instances where requests for a further interview or the continuation of an interview were declined.

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\* Undertaking, Appendix O.

## Schedule of hearings

Starting in February 2013, and throughout the proceedings, Participants and witnesses were advised of the anticipated schedule. Of necessity, this schedule was an evolving document that required constant adjustment to accommodate the availability of the witnesses and their counsel and to reflect the uncertainties inherent in the estimates of the time required for examination and cross-examination.

## Summonses to attend

All witnesses who testified before the Commission were compelled to attend by virtue of a summons to appear, which was served on them pursuant to subparagraph 10(1)(a) of the *Public Inquiries Act, 2009*.

Of course my powers to compel the attendance of a witness did not extend beyond the Ontario border. Although some witnesses residing outside Ontario voluntarily agreed to testify before the Commission (for example, Henrieth Laroue (McLeery) came from Alberta and Dave Munroe from Pittsburgh), I was faced with one recalcitrant witness from the United States who refused to offer up a representative to attend.

During Part Two, the Commission sought the assistance of Geophysical Survey Systems, Inc. (GSSI), a company based in Salem, New Hampshire. GSSI is the manufacturer of the LifeLocator III+, a device that the OPP used during the emergency response. Before the start of the hearings, GSSI provided valuable information through correspondence with Commission counsel.<sup>12</sup> However, when Commission counsel requested that a representative of GSSI, of its choosing, be present at the hearing to explain certain key issues,<sup>13</sup> the company declined the invitation.<sup>14</sup>

Subsequently, on October 2, 2013, counsel for GSSI advised that the company had not entirely ruled out testifying at the hearings. On October 4, 2013, counsel for GSSI was reminded that, should a representative wish to testify at the hearings, that person must be available to complete his or her testimony before the end of the day on October 8, 2013. The Commission received no response.

On March 5, 2014, five months after the conclusion of the hearings, counsel for GSSI sent a letter to Commission counsel providing additional submissions with respect to the proper functioning of the LifeLocator as well as the proper training of its operator. This letter was provided to the Participants, who were given an opportunity to respond to it if they wished to do so. Brief submissions were received from the OPP, Seniors' Action Group of Elliot Lake (SAGE), and the Ontario Fire Chief's Association. I did not find these submissions helpful in resolving the issues with respect to the reliability of the device.

## Website and information

The Commission was directed by its mandate to "promote accessibility and transparency to the public through the use of technology, including by establishing and maintaining a website." The Commission's bilingual website was created by Autcon, a company owned by Djordje Sredojevic. It contains virtually all the material on which this Report is based – all exhibits and all transcripts of evidence of the 125 witnesses heard over 118 hearing days. The hearings were webcast live and could be followed daily by the simple expedient of typing [www.elliottlakeinquiry.ca/](http://www.elliottlakeinquiry.ca/) in a search engine. The Commission's rules and my rulings, statements, schedules, biographies, and so forth, were instantly accessible to anyone interested in the process.

Individuals seeking to obtain information from the Commission or provide information they deemed relevant could also reach the Commission via email (info@elliotlakeinquiry.ca). Emails, which were received by the Commission on a regular basis, were vetted by Commission counsel, who took the necessary steps to pursue any relevant information.

## The Commission's Rules – general

The *Public Inquiries Act, 2009*,<sup>15</sup> provides that:

- 7. (1)** Subject to this Act and the order establishing it, a commission has the power to control its own processes and may make rules governing its practice and procedure.
- (2)** As examples of matters that may be dealt with in rules made under subsection (1), a commission may make rules with respect to the following:
1. The scheduling of activities for the conduct of the public inquiry, including dividing the public inquiry into phases or parts.
  2. Processes for determining who may participate in the public inquiry and the scope of any participation in the public inquiry.
  3. Time limits applicable to any of its proceedings and the extension or abridgement of time limits applicable to any of its proceedings.
  4. The service of notices and other documents.
  5. Adjournments.
  6. The transcription and recording of meetings and hearings.
  7. The collection, submission and receipt of information.
  8. Processes for determining any privilege claimed in respect of information.
  9. Fees and expenses payable to witnesses and participants.
- (3)** A commission may, for different persons or different classes of persons,
- (a) make different rules; and
  - (b) waive or modify the application of one or more of its rules.
- (4)** A commission shall ensure that its rules are made available to the public

One of Commission counsel's first duties was to draft Rules of Procedure\* and Rules of Standing and Funding† in accordance with the legislation and to post them on the Commission's website.

Following my Ruling on Standing and Funding issued November 8, 2012, Participants were invited to make submissions on desired changes or amendments to the Rules of Procedure. Revised rules were posted as changes were made.

Rules are essential to allow the Commission to control its process effectively and fairly. They cover areas such as granting of standing, limitations on participation, funding recommendations, document production, rules of examinations, Overview Reports, and privilege claims. Some aspects of the Rules of Procedure deserve specific mention, and I cover them below.

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\* Rules of Procedure (revised December 20, 2012), Appendix K.2.

† Rules of Standing and Funding (revised September 26, 2012), Appendix K.1.



## Standing and funding

### Standing

Section 16 of the Rules of Standing and Funding provide that Participants granted standing may have:

- a. Access to documents collected by the Commission subject to the Rules of Procedure;
- b. Advance notice of documents which are proposed to be introduced into evidence;
- c. Advance provision of will say statements of anticipated witnesses;
- d. A seat at counsel table;
- e. The opportunity to suggest witnesses to be called by Commission Counsel, failing which an opportunity to apply to the Commissioner to lead the evidence of a particular witness;
- f. The right to cross-examine witnesses on matters relevant to the basis upon which standing was granted;
- g. The right to make closing submissions.
- h. The opportunity to apply for funding pursuant to the Rules on Standing and Funding.

Section 11 of the Rules of Standing and Funding required me to consider the following factors in my determination to grant or refuse standing:

- a. whether a person has a substantial and direct interest in the subject matter of the Inquiry;
- b. whether a person is likely to be notified of a possible finding of misconduct under section 17 of the Act;
- c. whether a person's participation would further the conduct of the Inquiry;
- d. whether a person's participation would contribute to the openness and fairness of the Inquiry.

In September 2012, advertisements were placed in several national and legal publications seeking applications for standing and funding. Eighteen groups or individuals sought standing and/or funding and a hearing was held on October 26, 2012, in Elliot Lake to hear motions for standing and funding. (However, a number of persons and organizations / associations were advised beforehand that they did not need to attend the hearing.) Ultimately, I heard oral submissions from six applicants.

Individual applicants who had a commonality of interest without conflict were encouraged to form groups with a single grant of standing. In this regard, two of the original applicants, Peter Unfried and the Seniors' Action Group of Elliot Lake (SAGE), agreed to join with the Elliot Lake Mall Action Committee (ELMAC) and be represented by its counsel. I noted at the time that "should a conflict arise between SAGE and ELMAC, SAGE will be free to make a new application for standing."

In April, a dispute developed between SAGE and its counsel. I therefore granted separate standing to SAGE, although its members chose not to be represented by counsel.

A total of 34 individuals or groups of individuals were granted standing for participation in either Part One or Part Two of the proceedings, or both. Two applicants were refused standing, and one (Peter Unfried) withdrew his application.

In my Ruling on Standing and Funding dated November 8, 2012,\* I granted standing to the following individuals / groups:

**Parties – Full Standing**

- Réjean Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan
- Government of Ontario
- Corporation of the City of Elliot Lake
- Elliot Lake Mall Action Committee

**Parties – Part I Standing**

- Eastwood Mall Inc., Robert Nazarian and Levon Nazarian
- Non-Profit Retirement Residences of Elliot Lake Inc. and NorDev 1425164 Ontario Ltd.
- Robert Wood
- Greg Saunders
- Shoppers Drug Mart Associate #667, Martinette Venter
- Association of Professional Engineers of Ontario
- Ontario Building Officials Association
- Ontario Society of Professional Engineers

**Parties – Part II Standing**

- Ontario Association of Fire Chiefs
- Elliot Lake Professional Fire Fighters Association, IAFF Local 1351, Toronto Professional Fire Fighters Association, IAFF Local 3888, Ontario Professional Fire Fighters Association (OPFFA) and the International Association of Fire Fighters (IAFF)

Subsequently, as the investigation and hearings continued, I received applications for standing from several other individuals and entities, which I granted, namely:

- Algoma Central Properties Inc. (January 25, 2013)
- exp Global Inc. (formerly Trow Global Holdings Inc.) (March 1, 2013)
- Rod Caughill, development supervisor, Algoma Central Properties Inc. (March 4, 2013)
- Robert Leistner, Vice-President, Algoma Central Properties Inc. (March 21, 2013)
- City of Toronto (April 2, 2013)
- Tom Derreck (April 21, 2013)
- Coreslab Structures (May 8, 2013)
- Alexandre Sennett (July 10, 2013)
- Brian MacDonald (July 18, 2013)

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\* Ruling on Standing and Funding, September 26, 2012, Appendix M.1.

## Funding

The Commission's Order in Council provides:

11. The Commission may make recommendations to the Attorney General regarding funding to participants in the inquiry, to the extent of that participant's interest where, in the Commissioner's view, the participants would not otherwise be able to participate in the inquiry without such funding. Such funding shall be in accordance with applicable Management Board of Cabinet directives and guidelines.

It is important to note that, unlike the issue of standing, where my decisions were final, I only had the power to recommend funding for Participants to the Attorney General. The final decision on whether to grant it belonged to that ministry.

Section 23 of the Rules of Standing and Funding required me to consider the following factors in my determination to recommend funding:

- a. the nature of the applicant's interest and/or proposed involvement in the Inquiry;
- b. whether the applicant has an established record of concerns for and a demonstrated commitment to the interest it seeks to represent;
- c. whether the applicant has special experience or expertise with respect to the Commission's mandate; and
- d. whether the applicant has attempted to form a group with others of similar interests.

On October 15, 2012, I also issued Procedural Order No. 1, in which I drew the attention of the persons applying for funding to Rule 21 of the Rules of Standing and Funding and, more specifically, to Rule 21(c), which describes the evidence that must be filed in support of such a request.

I made recommendations for various levels of funding in relation to six applicants. All my recommendations were accepted by the Attorney General.

In my Ruling on Standing and Funding dated November 8, 2012,\* I recommended funding to the following Participants:

- Elliot Lake Mall Action Committee
- Corporation of the City of Elliot Lake
- Ontario Building Officials Association

I was not, however, prepared to recommend funding for Eastwood Mall Inc., Bob Nazarian and Levon Nazarian, the last owners of the Mall, given the "incomplete nature of the materials provided."

I further indicated in my ruling that "at all times I expect parties with similar interests to co-operate with one another and with Commission counsel to avoid repetition and delay. I will not hesitate to intervene to ensure these limits are respected and this Inquiry is conducted in a fair but expeditious manner."<sup>†</sup>

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\* Ruling on Standing and Funding, September 26, 2012, Appendix M.1.

† Ruling on Standing and Funding, September 26, 2012, Appendix M.1.



Subsequently, as the investigation and hearings continued, I received applications for funding from other individuals and entities, which I recommended receive funding, namely:

- Ontario Association of Fire Chiefs (January 10, 2013)
- Thomas Derreck (April 21, 2013)
- Alexandre Sennett (July 10, 2013)\*

On April 9, 2013, I received a request to recommend additional funding to the City of Elliot Lake. In a supplementary ruling issued April 21, 2013, I concluded that the request was justified and recommended to the Attorney General that the additional funding be provided, stating:

5. The applicant's central role and that of its elected officials and employees are a constant and uninterrupted thread running through the entirety of the Commission's mandated examination of events commencing with historical events preceding the Algo Mall's construction until the post-collapse dismantling of the structure. It is now clear to me that no other participant has so central, important and ubiquitous an engagement with matters of concern to the Commission.

An independent assessment officer, Freya Kristjanson, was appointed by the Attorney General to ensure that all submitted expenses were in conformity with my recommendations and with Management Board of Cabinet directives and guidelines.

I was relatively liberal in my recommendation to the Attorney General that he fund Participants' counsel (and sometimes more than one counsel) to spend adequate time preparing for and attending hearings, given the importance of the hearings to Participants' interests. However, I applied a different standard for requests for Participants to attend the policy roundtables. These sessions were designed to be non-adversarial and non-confrontational, with little opportunity for Participant interaction, save for a relatively short question period at the end of each roundtable. I was satisfied that this involvement could be achieved at a distance via electronic means (the roundtables were webcast in the same way as were the evidentiary hearings) and did not require either personal attendance or extensive preparation by counsel for the Participants.

On February 26, 2013, clarification was sought from counsel for the Ontario Building Officials Association (OBOA) with respect to the limits I had recommended regarding the attendance and participation of Participants at the roundtables. I clarified that, exceptionally, I was prepared to recommend the full payment of the fees and expenses of OBOA's counsel, given the specific invitation that had been extended to him to participate in the roundtables.

On June 9, 2014, the OBOA sought my recommendation with respect to the funding of its participation in the application by Mr. Wood, which I discuss below. Although I valued the advice and expertise of counsel for the OBOA, I was not prepared to recommend full funding for OBOA counsel to prepare a response and attend in Ottawa at the hearing, given that I was nearing the budgetary limits of my mandate and I was committed to doing everything I could to respect that limit. I welcomed, however, a succinct written submission on the matter and recommended modest funding for that narrower purpose. The OBOA did file such a response.

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\* On July 23, 2013, I issued a further Supplementary Ruling on Funding with respect to Mr. Sennett clarifying two issues in my ruling of July 10, 2013.

## Payment by the Ontario government and withdrawal by counsel

Early in the hearings, an issue arose about the speed – or lack thereof – with which the Ontario government was paying the accounts for fees and disbursements submitted by counsel who had received funding. On April 19, 2013, Douglas Elliott, counsel for ELMAC and SAGE, informed me that, with the consent of his clients, he was withdrawing from further participating in the hearings because he had not yet been paid by the Ontario government. He stated:

I think this is extremely disrespectful of the Commission. I think it is disrespectful of the people of Elliot Lake. The people of Elliot Lake have learned through this Inquiry that there have been people who have put money ahead of the interests of the people of Elliot Lake, and regrettably, it appears that the Government of Ontario is doing that now.<sup>16</sup>

Although Mr. Elliott was paid within a few days and returned to the proceedings, I am nonetheless concerned with what transpired on two issues: (1) payment by the Ontario government; and (2) the unilateral decision to withdraw by counsel without permission from the Commission. I address each of these in turn.

During the initial stages of the Commission's existence, timely salary payments and reimbursements were a recurring and annoying reality and a significant hardship for members of my staff with earnings at the lower end of the salary scale.

The same can be said of the Participants' lawyers whose fees and disbursements were not paid in a timely manner at the beginning of the Inquiry. I therefore *recommend* that, once the government agrees to provide funding to Participants at an inquiry following a recommendation to that effect by the commissioner, it appoints its independent assessment officer and pays their lawyers' accounts for fees and disbursements as expeditiously as possible to prevent any unnecessary delays and controversy during the proceedings. These fees are usually heavily discounted in comparison with the fees normally charged by law firms to commercial clients (or in comparison to fees normally regarded as reasonable by the courts when assessing costs in civil proceedings). In addition, when a commission holds hearings in as remote a location as Elliot Lake, the disbursements borne and carried by the Participants' lawyers can be substantial.

With respect to the removal from record by counsel for ELMAC and SAGE, as I expressed during the hearings, I was quite concerned that permission was not sought from the Commission before such action was taken and that I received no forewarning.<sup>17</sup> I was even more surprised when I was then advised that SAGE had not been informed by its counsel of their decision to withdraw and was advised only after the fact.<sup>18</sup>

Counsel for ELMAC argued before me that the obligation of counsel to seek leave of the tribunal to withdraw is different in the context of a Commission and is not analogous to a civil or criminal proceeding. He argued that the client's interest in the context of a commission does not parallel those of a client in a civil or criminal proceeding.<sup>19</sup> I disagree. Rule 2.09(1) of the Rules of Professional Conduct<sup>20</sup> provides that a lawyer shall not withdraw from representation of a client except for good cause and upon notice to the client appropriate in the circumstances. This rule implies that notice to the tribunal be given and that permission be sought. In this regard, I agree with the submissions made to me by Commission counsel:

I would not treat any of those tribunals or courts any differently in respect of the fundamental matter of respect for the tribunal, respect for the process, and the necessity to ensure decorum and respect amongst all participants at all times. In my respectful submission, it is fundamental to the nature of that respect that is required both from the participants to the tribunal, and the concomitant respect from the tribunal to the participants, that communication is made before a lawyer ceases to appear for a client.<sup>21</sup>

## Privilege claims

Paragraph 8(3) of the *Public Inquiries Act, 2009*, provides that no information may be received and accepted by a commission that would be inadmissible in a court by reason of any privilege under the law of evidence. Consequently, Rule 11 of the Commission's Rules of Procedure outlines the procedure to be followed if a participant or a recipient of a summons objects to the production of documents on the grounds of privilege. The rule states that the Commissioner may determine the privilege issue or, at his or her option, refer the matter for determination by a third party. The latter course of action is often preferred and, for this Commission, Mr. Justice Stephen Goudge of the Ontario Court of Appeal graciously accepted to act as *persona designata* for this purpose and is referred to in Rule 11(c). Two claims for privilege were dealt with by Mr. Justice Goudge and were determined on June 28, 2013.\*

## Overview Reports

During the Commission's collection of information and evidence, I was mindful of these provisions of the *Public Inquiries Act, 2009*:

- paragraph 8(1), which provides that a commission may collect and receive information that it considers relevant and appropriate, whether or not the information would be admissible in a court and in whatever form the information takes, and may accept the information as evidence at the public inquiry; and
- subparagraph 9(1)(f), which provides that a commission shall, as much as practicable and appropriate, refer to and rely on any other document or information, if referral to and reliance on the document or information would promote the efficient and expeditious conduct of the public inquiry.

Rule 19 of the Commission's Rules of Procedure provides that the Commission may prepare Overview Reports, which may contain core or background facts. The rules also provide that the Overview Reports could be used to assist in identifying systemic issues relevant to the Inquiry (Rule 21). Rule 22 provides that the Commission would rely, whenever possible, on the Overview Reports instead of calling witnesses.

A number of these reports were filed as exhibits at the outset of the hearings for Parts I and II, including a report on the history of the City of Elliot Lake and an overview of the incident management system.†

Participants were offered the opportunity to comment on the reports before they were entered as exhibits. The comments were received and considered. These reports allowed for the admission in evidence of relevant and generally uncontroverted but pertinent information without the necessity of calling witnesses. These reports were practical timesavers. It would have been impossible to have a witness speak to every one of these documents and still meet the time constraints imposed on us by the Order in Council.

Many of the Overview Reports also included numerous documents collected by the Commission during its investigation.

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\* Reasons of Goudge JA dated June 28, 2013, Appendix M.5.

† List of Overview Reports, Appendix L.



I was satisfied with the *prima facie* relevance and importance of the information contained in these documents. However, I did not consider them conclusive. Participants were invited to present evidence or to cross-examine to challenge the content of the reports. Only after that stage did I feel free to reach definitive conclusions relating to them and to make what I considered to be appropriate findings of fact.

## Confidentiality

Paragraph 10(3) of the *Public Inquiries Act, 2009*, states that a commission may require the provision or production of information that is considered confidential or inadmissible under another act. Nonetheless, paragraph 14(3) provides that a commission may exclude the public from all or part of a hearing or take other measures to prevent the disclosure of information.

Rule 17 of the Commission's Rules of Procedure deals with the procedure to be followed when a participant or summons recipient objects to the disclosure of documents or information on the grounds of confidentiality.

Bob and Levon Nazarian and Eastwood Mall Inc. sought an order preventing disclosure of all documents filed in support of their application for funding made to the Commission. The Association of Professional Engineers of Ontario requested an order under the *Professional Engineers Act* that, before the disclosure of any documents produced in response to a Commission summons, certain named and unnamed individuals be given the opportunity to review the documents and make submissions as to the appropriateness of further disclosure. The applications were contested. After a full hearing in Ottawa on December 17, 2012, both applications were dismissed.\*

## Section 17 notices

Section 17 of the *Public Inquiries Act, 2009*, provides that

- [a] commission shall not find misconduct by a person unless,
  - (a) reasonable notice of the possible finding and a summary of the evidence supporting the possible finding have been given to that person; and
  - (b) the person has been given a reasonable opportunity to respond.

This Commission is prohibited by its Order in Council, and by the governing jurisprudence, from expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization. The Commission is, however, required to find the facts in respect of the matters it is directed to inquire into.

One of the principles guiding this Commission throughout has been the need to ensure procedural fairness to those persons who may be affected by its activities. I am well aware that, as Justice Peter Cory noted in *Canada (Attorney General) v Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*,<sup>22</sup> findings of misconduct (which he defined

**This Commission is prohibited by its Order in Council, and by the governing jurisprudence, from expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization.**

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\* My ruling appears at Appendix M.2.

as including “improper or unprofessional behavior” or “bad management”) should not be the principal focus of this public inquiry. They should be made only in those circumstances where they are required to carry out the inquiry’s mandate. Nevertheless, it may well be necessary to make findings of misconduct. As Justice Cory wrote:

The findings of fact and the conclusions of the commissioner may well have an adverse effect upon a witness or a party to the inquiry. Yet they must be made in order to define the nature of and responsibility for the tragedy under investigation and to make the helpful suggestions needed to rectify the problem ... procedural fairness is essential[,] for the findings of commissions may damage the reputation of a witness. For most, a good reputation is their most highly prized attribute. It follows that it is essential that procedural fairness be demonstrated in the hearings of the commission.<sup>23</sup>

Neither the statute nor the jurisprudence defines the standard to be applied when determining whether a notice ought to be issued about a possible finding of misconduct. In my view, the appropriate standard, keeping in mind the Commission’s fairness obligation, has been a determination that there is evidence which, if accepted, and in the absence of an explanation, could be the basis for a finding that the person had mismanaged matters relating to the structural integrity of the Mall or relating to the emergency management and response.

Commission counsel and I agreed that we would give section 17 of the *Public Inquiries Act, 2009*, an expansive interpretation, both in the interest of fairness and to avoid being constrained by the section when time came to write this Report. Consequently, I directed counsel to err on the side of issuing more of these notices rather than fewer, knowing that I was not likely to find misconduct in the terms set out in every notice. That direction was explained as clearly as possible in the correspondence accompanying the notices, but in many cases caused some degree of concern. I also directed counsel to issue the notices as far in advance as possible before the witness’s attendance to give evidence. Counsel adhered to that procedure with few exceptions. Unanticipated evidence, for example, led of necessity to the issuance of supplementary notices.\* Commission counsel drafted all section 17 notices.

For obvious reasons, the fact of the issuance of a section 17 notice was kept rigorously confidential by the Commission.

Pursuant to paragraph 17(2) of the *Public Inquiries Act, 2009*, recipients of section 17 notices were afforded the same rights as persons who had been granted standing as Participants. They had the right both to participate in the Inquiry and to be represented by counsel. They could also apply for a funding recommendation.

## Conduct of the hearings

Hearings were held at the White Mountain Building in Elliot Lake beginning on March 4, 2013, and ending on October 9, 2013 (in addition to one day for oral submissions relating to Part Two), for a total of 118 days. During that time, the Commission heard 118 witnesses. One week preceding the hearings was spent testing the equipment and facilities and doing a dry run and demonstration with the Participants.

A typical hearing day began at 9 a.m. and ended at 5 p.m., with short breaks for health and lunch. The only interruption was between June 17 and July 5, 2013. Sitting weeks were four days – Tuesday through Friday, and Monday through Thursday – with a four-day weekend every other week to permit staff and counsel to return to Ottawa to look after personal and professional business.

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\* A generic example of such a notice, containing no confidential information, is found at Appendix Q.

Witnesses who testified provided their evidence under oath or affirmation. Each witness was entitled to have his or her counsel present while testifying. The Rules of Procedure governed the procedural pace of the examination of witnesses. Examination-in-chief was always conducted by Commission counsel. If the witness had counsel present, they were entitled to examine-in-chief and/or re-examine.

The Rules of Procedure permitted Commission counsel to ask leading questions. On occasion, Commission counsel cross-examined with respect to credibility. This was necessary in order to establish the facts in accordance with my mandate. I agree with the Honourable Dennis O'Connor, who wrote in his *Report of the Arar Inquiry*:

It is often said that Commission counsel's role in a public inquiry is to lead the evidence in an independent and fair manner, and that Commission counsel should neither advocate a particular position nor set out to "prove a case." I agree with this description. The fact that Commission counsel may, in some circumstances, be required to cross-examine witnesses need not compromise the independence or fairness of their position. Cross-examinations, even challenging ones, can be carried out fairly and even-handedly, and need not result in Commission counsel adopting an adversarial or prosecutorial role.<sup>24</sup>

The Rules of Procedure also provided that neither Participants nor Commission counsel were entitled to cross-examine a witness on any will-say statement that may be provided, except with my leave (Rule 45). Leave was never sought from me. Participants' counsel invariably agreed on the order of cross-examination without the necessity of my intervention. As a general rule, cross-examinations were relatively short. I was not required to impose any time limitation. Counsel intending to present a document to a witness were required to give all counsel advance notice.

The examinations of two witnesses, James Keywan and Roger Pigeau, were conducted by video-conference to accommodate their age and state of health. Sophisticated electronic equipment allowed these examinations to unfold smoothly, but the process was far from cost-free. Setting up facilities and equipment permitting two-way visual and audio real-time communications is an expensive endeavour.

Neeson & Associates provided real-time / expedited reporting and transcript services, meaning that the transcript could be viewed from a screen in the hearing room and a rough draft of the transcript would be available for consultation only a few hours after the conclusion of each day's evidence. The transcript was posted on the Commission's website. The quality of this company's services and the professionalism of its staff were superlative. Search features at the end of each day's transcript were particularly useful. In addition, it was possible to access the exhibits directly from the transcript via a hyperlink feature.

I was aware that some aspects of the evidence, particularly in Part Two, might be upsetting for family members and other residents of Elliot Lake. For example, there was graphic evidence about the injuries suffered by the victims of the collapse and videos of the collapse. I asked counsel to provide advance notice when such evidence was about to be presented so that I could issue the appropriate warnings. I also issued a publication ban on August 29, 2013, and restricted the dissemination of certain exhibits outside the hearing room and press room, ordering that they not be shown on the webcast version of the proceedings.

## Oral submissions by Participants

Oral submissions at the end of each part were succinct and were generally completed in less than the time allotted to each Participant. At my direction, Commission counsel made no concluding oral submissions.



## Motion to adduce evidence by James Keywan

On June 21, 2013, John Brunner, counsel for James Keywan, who was the original architect of the Algo Mall, filed a motion and supporting materials seeking an order granting him the right to introduce rebuttal evidence from an expert witness at the Inquiry pursuant to Rule 31 of the Commission's Rules of Procedure and section 17.1(b) of the *Public Inquiries Act, 2009*. Mr. Keywan was seeking to introduce the report of architect Allan Larden dated May 14, 2013 (the Larden Report).

On June 24, 2013, counsel for the Elliot Lake Mall Action Committee submitted responding materials opposing the filing of the Larden Report or permitting Mr. Larden to testify at the Inquiry. On July 15, 2013, I ruled that Mr. Larden's report would be filed and all Participants would be given the right to cross-examine Mr. Larden. I stated:

At this stage of the proceedings of the Commission, I am not prepared to be constrained or restricted in arriving at the findings and conclusions encompassed by my mandate ... I am sensitive to counter any perception of unfairness to any Participant or section 17 recipient constrained to appear to give evidence before the Commission or to those who have the right to cross examine.\*

Mr. Larden testified before the Commission on July 30, 2013.

## Application by Robert Wood

On April 25, 2014, counsel for engineer Robert Wood wrote Commission counsel, advising that he intended to bring an application seeking an order that my Report be redacted before being publicly released to delete any reference to Mr. Wood, and that the redacted portions not be released publicly until the completion of the charges brought against Mr. Wood under the *Criminal Code*.

On April 29, 2014, I issued Procedural Order No. 7 setting out the process to be followed by Mr. Wood, the items his application should contain, and a schedule for the application.†

Mr. Wood did not then, as he had indicated that he would, make an application for an order that portions of the my final Report be redacted before its public release. Instead, on May 20, 2014, counsel for Mr. Wood served and filed a Notice of Application seeking, among other things, an order that he and his counsel be permitted to review the final draft of the Report in advance of its being made public to determine whether, in their opinion, there were passages that would affect Mr. Wood's right to a fair trial. Mr. Wood also sought orders setting out the procedure to be followed for the determination of a subsequent application for redaction of specific passages and references "if necessary."

On May 22, 2014, I issued Procedural Order No. 12, setting out concerns I had about the application, including a possible jurisdictional issue, as well as the procedure to be followed for determination of Mr. Wood's application (including the filing of responding submissions).‡

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\* Ruling on Keywan motion, Appendix M.4.

† Procedural Order No. 7, Appendix K.4.

‡ Procedural Order No. 12, Appendix K.7.

On May 30, 2014, Mr. Wood served an Application Record containing a Notice of Amended Application, in which he abandoned his initial application for an order allowing him a preliminary review of the Report of the Commission before its delivery. Mr. Wood sought instead an order that the Report be redacted of “only passages that deal with the matter of the Applicant’s Section 17 notice.” He also sought an order that the redactions be removed from the Report of the Commission immediately following the event of:

- a) The Applicant electing a trial of the Criminal Code matters before an Ontario Court of Justice or
- b) The Applicant electing a trial of the Criminal Code matters before a judge sitting without a jury or
- c) The Applicant or the prosecutor [requesting] a preliminary hearing following the Applicant electing to be tried before a court comprised of a judge sitting with a jury and the Applicant ... not [being] committed to stand trial following the completion of the preliminary hearing or:
- d) The applicant [being] acquitted or convicted following the trial of the Applicant before a judge sitting with a jury.

The Ontario Building Officials Association, the Province of Ontario, and a group of media organizations (made up of the Canadian Broadcasting Corporation, the *Globe and Mail*, and Canadian Press Enterprises Inc.) filed responding submissions. A hearing was held in Ottawa on June 20, 2014.

On July 28, 2014, I dismissed Mr. Wood’s application:\*

Mr. Wood had to show that the publication of the Commission’s report would pose a serious threat (grounded in evidence) to the proper administration of justice through a risk to his fair trial rights. In light of the alternative methods available to address any concerns regarding the impact the publication of the Report may have on potential jurors, I am not convinced that the Report will impair Mr. Wood’s rights under s. 11(d) of the *Charter* and I therefore conclude that he has failed to discharge this heavy onus.

## 1988 *Deterioration of parking structures* report

On May 8, 2014, the Commission received an anonymous letter enclosing a report entitled *Deterioration of parking structures*. The report, dated July 1988, had not been produced to the Inquiry during its investigation and appeared to have been prepared by an Advisory Committee struck by the Ontario Ministry of Housing. Members of the Advisory Committee included individuals from the Ministry of Housing, Trow Group, Halsall Robt & Associates Ltd., and Construction Control Ltd.

On May 12, 2014, I issued Procedural Order No. 9 in which I sought submissions from the Province of Ontario and the Participants to Part One of the Inquiry.†

Submissions were filed by the Province of Ontario, exp. Global Inc. (formerly Trow), Robert Wood, the Ontario Building Officials Association, and the City of Elliot Lake, which I considered and led me to the preparation of an addendum to the first part of my report.

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\* Ruling on Wood application, Appendix M.6.

† Procedural Order No. 9, Appendix K.6.

## Opportunity to make further submissions

On May 1, 2014, I issued Procedural Order No. 8, describing the process to be followed in the event that individual Participants were given an opportunity to make further submissions on particular issues. I directed that any such submissions be posted on the Commission's website and that notice of the submissions be provided to all Participants in the part of the Inquiry to which the submissions related. I ordered that all such Participants be entitled to provide a written response to the submissions and that the responding submissions also be posted on the Commission's website.

## News reporting, media relations, and communications

Technology made it possible for the public to follow the hearings through a variety of sources without having to be in the Elliot Lake hearing room. Foremost among these sources were the Inquiry's live webcast and the transcripts posted on the web page at the end of each day. For people not able to watch in real time, the webcast was archived on Ustream, a web-streaming service similar to YouTube, where each day's video could be watched at any time. The webcast remained online for a period after the end of the Inquiry. The live proceedings were translated simultaneously into French.

Area residents also had the opportunity to watch the hearings on Eastlink, the cable company that services the area, with a day's delay. The Eastlink station in Sudbury picked up a physical copy of the day's proceedings each evening and broadcast it at 1 p.m. the following day.

Several media outlets reported on the hearing, among them the *Elliot Lake Standard*, Sudbury CBC, Radio-Canada, CTV, Global Television, and the Canadian Press.

I decided early on that I would not grant any media interviews or make any statements concerning the work of the Commission except officially on the record from the dais or in print on the Commission's website. Media relations were handled by Peter Rehak, the Commission's highly experienced media consultant, and interviews or questions about the work of the Commission were answered on my behalf by Commission counsel – Peter Doody, Bruce Carr-Harris, and Mark Wallace in English and Nadia Effendi in French. All correspondence was similarly handled by counsel, except for official communications between me and the Attorney General relating to such matters as funding recommendations or budgetary issues. At various stages, I made public official statements regarding the work of the Commission.\*

Inevitably, I received a number of letters and messages from individuals wishing to provide me with confidential or "inside" information about the subject matter of the Inquiry. In the interest of fairness and impartiality and the appearance thereof, I studiously avoided reading or responding to this material and had it screened by clerical or legal staff, who would respond as necessary.

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\* All such statements appear in Appendix J.



## The roundtables of experts

To assist in formulating my recommendations, I convened a series of policy roundtables after the completion of the evidence and closing submissions. Each roundtable, chaired by a Commission counsel, consisted of a number of experts who considered a series of questions prepared by Commission staff. These questions were also designed to reflect the recommendations made by Participants in their closing submissions.

For Part One of the Inquiry, the first roundtable discussed issues related to the inspection of buildings, to property standards, and to the training and qualifications of building officials. The second roundtable examined whether there should be greater sharing of reports and information relating to the conditions of buildings. The third roundtable focused on the role of architects, engineers, and building inspection companies. The Part Two roundtable examined issues relating to the conduct and management of an emergency response and the entities that may respond to an emergency.

Unlike for the factual hearings, I decided to convene these roundtables in Ottawa, for reasons of economy. However, the sessions were webcast on the Inquiry's website and screened in Elliot Lake. Observers in Elliot Lake had the opportunity to pose questions at the end of each roundtable, either by telephone or through email.

I attempted to include in the roundtables representatives from all the sectors that could be affected by my possible recommendations. The Commission also received written submissions in advance from each of the organizations represented by these individuals, from the Ontario Association of Architects, and from Ontario's Large Municipalities Chief Building Officials.

The purpose of the roundtables was to allow stakeholders and persons with experience and expertise in these areas to discuss policy recommendations under consideration by the Commission. All the Participants took an active role in the discussions. The representatives of the Ontario public service understandably took the position that, since the Commission had been established to provide advice to the Government of Ontario, their role was to offer relevant information from Ontario's experience with the issues under consideration rather than advocating specific positions on the topics discussed.

I am grateful to all the experts who took time out of their busy schedules to assist the Commission in its work.\*

## Drafting the Report

After almost seven months of hearings, I had to review and consider evidence from 118 witnesses consisting of more than 29,000 pages of transcript, as well as more than 11,000 exhibits.

The evidence was summarized and distilled in Excel spreadsheets by Commission counsel as soon as the hearings were completed. To ensure that the summaries of the evidence could subsequently be used effectively for the purposes of fact-finding and analysis, we determined that each noteworthy and relevant piece of evidence would form one entry in the spreadsheet, accompanied by a date (and time, for Part Two) and the precise reference to the transcript and exhibits. The Part One summaries included 3,700 entries, while Part Two included 1,400 entries. All the summaries were then merged into one spreadsheet and sorted in chronological order, permitting a systematic and coordinated review of the evidence. This was a laborious and time-consuming exercise. I am grateful to counsel for the hundreds and hundreds of hours spent on this onerous task.

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\* The questions discussed at the roundtables for Part Two and the names of the Participants appear in Appendix D.

I decided that it would make sense to divide my Report into two volumes, reflecting the two Parts of my mandate and the two parts of the hearings that had taken place. The first volume, Part One, dealt with all events from the construction of the Mall to its eventual collapse. The second volume, Part Two, would deal with the emergency response to the collapse. It would also include this chapter on the Inquiry process.

For Part One, following the summarizing of the evidence, narratives of each of the three ownership periods of the Mall (Algocen years, Retirement Living years, and Eastwood Mall years) were prepared by counsel for my review and final redaction, assisted by my editor, along with a chapter on the causes of the collapse. The narrative for Part Two was apportioned among counsel in a chronological order (starting from the time of the collapse to the recovery of the victims and debriefing conducted by the responders). An additional chapter was drafted on the cause and time of deaths of the victims, before being submitted to me. I then drafted a chapter, for each of Parts One and Two, analyzing the specific issues emerging from the evidence and the conclusions that I drew from that exercise.

Further, for each of Parts One and Two, an appendix describing the roundtables was drafted. Finally, and perhaps most importantly, a chapter containing the Commission's recommendations was composed.

Shipton, McDougall Maude Associates were hired to edit and prepare the Report for printing. H3Creative Inc. was retained to plan the design and layout as well as to coordinate and to supervise the translation and printing of the Report.

## Amendment to the Order in Council

Several unanticipated circumstances required that the Commission seek an amendment to its Order in Council, extending the time for the delivery of its Report, and seek the minister's permission to revise its budget.

At the time of my appointment as Commissioner, a principled determination of the time required for the Commission to carry out its mandate would have been impossible. It was only after the initial investigative stage, which lasted until February 2013, that Commission counsel and I developed a meaningful grasp and understanding of the magnitude of the problem the Commission was tasked to analyze. Indeed, it was only then that the Commission was able to fix a tentative schedule for the hearings.

As I explained above, the investigative stage could begin only after Commission counsel and staff were recruited and after temporary premises in Ottawa were found and equipped. The Commission's offices and infrastructure were up and running only in late September 2012, in part because of the difficulty in locating suitable space. The investigation was a cumulative and progressive process involving the issuance and service of well over 100 summonses and the collection, coding, and analysis of many thousands of responding documents, the interviewing of witnesses, and the preparation of briefs, will-say statements, and other documents for each witness. The breadth of that endeavour, particularly in relation to the events preceding the Algo Mall collapse, was due to the age of the Mall itself. The Commission's research covered a period of more than 30 years.

As I have explained in greater detail above, hearings had to be conducted with respect to standing and funding as well as confidentiality.

Furthermore, as I advised the Participants during the confidentiality hearing on December 17, 2012, two reasons contributed to the hearings not commencing before the beginning of March 2013. First, the response to Commission document production summonses was not always timely. Late production of documents was a recurring reality throughout the hearing phase, particularly from the Ontario government and the last owner of the Mall. Second, the completion date for the refurbishment of the hearing facility at the White Mountain

Academy was delayed until February 2013, when the Commission had been assured that construction would be complete by December 1, 2012.

In November 2013, I wrote the Attorney General seeking an extension of the original January 2014 deadline.\* In December 2013, Order in Council OC 1873/2013 extended the deadline for delivery of a final Report to October 31, 2014.†

Although I fully recognize the right and responsibility of the government to impose a deadline on the work of an Inquiry, such a deadline must be realistic, given the mandate and scope of work. It must also take into account all the “setting up” required before the actual work can begin. As discussed, staff must be retained, offices located, computers rented. Competent and experienced counsel cannot simply drop everything to begin work instantly on the Inquiry. Offices do not magically appear. I would *recommend*, therefore, that any deadline imposed by the government include a reasonable period of set up time and that the government ensure that its resources are in place to assist the Inquiry in the basic organizational phase of its work. In the case of this Commission, I found the government was very slow or ill equipped to assist with essential prerequisites such as locating suitable office space, providing accounting services, and obtaining specialized resources.

## Acknowledgements

Being appointed to head a commission of inquiry is a privileged and unique experience, and one for which I was singularly unprepared.

I have been a provincial court judge for more than 36 years, presiding over thousands of criminal trials. I had administrative duties as a regional senior judge for 12 of those years. Those experiences, however, did not adequately prepare me for the whirlwind that was to follow my appointment to lead this Inquiry. Judges are coddled and pampered persons – from the moment of their appointment, everything is provided to them. When I accepted the premier’s invitation to head up the Elliot Lake Commission of Inquiry, I possessed only one asset: me!

A commission does not come equipped with anything. In a very short time, a commissioner must create a sophisticated organization, similar to a small government agency. Furniture and equipment – ranging from pencils to computer systems, desks to telephones – must be purchased, leased, rented, or borrowed. Offices must be found and equipped. Contracts must be entered into for accommodation, document retrieval and analysis, translation and interpretation, stenography, transportation, webcasting, audio-visual equipment, and report design and printing – to name a few tasks.

And, most important of all, a cohesive staff must be assembled.

This Inquiry was presented with unique problems owing to the relative remoteness of the location of its subject. Recruiting legal counsel locally in Elliot Lake was virtually impossible. The Elliot Lake bar is very small, and most of the local lawyers had already been retained to represent persons and interests involved in this tragedy. Because I reside and work in Ottawa, it was consequently logical to recruit Ottawa-based counsel who had construction law, criminal law, and inquiry experience. In addition, it was important that at least some members of my legal team be bilingual, owing to the bilingual character of the City of Elliot Lake. Although hearings would of necessity take place in that city, much of the organizational and preparatory work could be done in Ottawa.

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\* Letter to Attorney General, see Appendix R.

† Order in Council OC 1873/2013, see Appendix G.



That meant leasing office premises both in Ottawa and in Elliot Lake, as well as facilities for hearings in the city where the Algo Mall had been located. Facilities for roundtable sessions were also found in Ottawa.

After the shock of my appointment wore off and reality crept in, my first priority was to recruit an executive director whose knowledge of organizational processes would be an absolute essential. I was extremely fortunate to find Suzanne Labbé early on. I knew Suzanne from her days at the office of the Commissioner for Federal Judicial Affairs in the late 1990s. We also worked together on various international judicial reform projects, and I was impressed by her diplomatic skills and administrative ability. She joined the Courts Administration Service as deputy chief administrator responsible for judicial affairs in March 2005 and retired from the public service in July 2011. At the time that she agreed to assist me as executive director of the Commission, she had just completed her term as executive director of the 2011–12 Judicial Compensation and Benefits Commission. Suzanne is fluently bilingual. Her constant and caring support, quiet and sound advice, and depth of experience were invaluable.

My next priority was to seek advice. Invariably, those I sought assistance from were immediately responsive and very generous. Their collective experience and expert guidance provided me with a solid base on which to build. They were all very kind and patient with a rookie commissioner. I list their names in no particular order:

- Regional Senior Justice Lise Maisonneuve, Ontario Court of Justice, Ottawa;
- Regional Senior Justice Charles Hackland, Ontario Superior Court, Ottawa;
- Chief Justice Annemarie Bonkalo;
- George Thomson (former head of the National Judicial Institute and former federal and provincial deputy minister of justice);
- Ed Ratushny (author of a leading textbook on commissions of inquiry);
- David Scott (dean of the Ottawa bar);
- P. Donald Rasmussen (expert in construction law);
- Associate Chief Justice Dennis O'Connor (retired) (headed two commissions of inquiry);
- Mr. Justice Stephen Goudge (headed the Inquiry into Pediatric Forensic Pathology in Ontario);
- Madam Justice Denise Bellamy (headed the Toronto Leasing Inquiry);
- Mr. Justice Sidney Linden (headed the Ipperwash Inquiry);
- Paul Cavalluzzo (commission counsel on two inquiries); and
- Linda Rothstein (commission counsel at the Goudge Inquiry) and Tina Lie, both of whom acted for the Commission in the Application for Stated Case against the Nazarians.

## Legal staff

Instead of one senior commission counsel, I chose three. They were the people whose assistance I sought, and their respective ability and experience did not permit distinction:

- Bruce Carr-Harris
- Peter Doody
- Mark Wallace

Collectively, these three senior members of the Ottawa bar had the experience of working on eight previous commissions of inquiry. Their expertise in construction litigation, general litigation, and criminal law is widely recognized and deeply respected, and I was amply rewarded by choosing them. They worked seamlessly and

energetically as the core of the Commission's legal team. Their wise advice and consummate skills as advocates were of inestimable assistance to me.

They were soon joined by Nadia Authier, Nadia Effendi, and Nigel Marshman, all fluently bilingual. The intellectual brilliance and prodigious work ethic of these three lawyers challenged and amazed me every day. Two of them had clerked for the Supreme Court of Canada, and Mr. Marshman had worked on three previous inquiries. Two younger lawyers, Duncan Ault and Natalia Rodriguez, were felicitous additions as associate counsel, and their hard work enhanced that of the Commission. They were joined by our articling student Ivana Nenadic, who not only gained the practical experience needed to be called to the Ontario Bar in June 2013, but also had the rare opportunity to question a witness before the Inquiry. Kyle Lambert joined the team in June 2013 as special assistant to counsel, and Ms. Nenadic returned in September to replace him. Ms. Rodriguez left shortly before the completion of the Commission's work to become one of two new mothers on the team. In the summer of 2014, Stéfanie Lacroix, a summer student with Borden Ladner Gervais, assisted with editing.

I owe a deep debt of gratitude to my legal team. They all possess academic and professional distinctions and awards. They worked as an effective and co-operative unit from the outset. During the hearings, they were required to be away from their families and other loved ones from late February until October of 2013. All worked late into weekday evenings and on weekends in preparation for forthcoming hearings, preparing briefs, interviewing witnesses, or sorting through mountains of documents. That list is far from exhaustive. Their schedule was punishing: hearings began at 9 a.m. and continued until 5 p.m. every weekday, with short meal and health breaks. Their advice to me was invariably generous, wise, and freely given. Their enthusiasm and energy was inspiring. This Report is overwhelmingly their report.

## Media relations

Media relations were entrusted to Peter Rehak, who has undertaken this role for virtually every commission of inquiry in Ontario in the past dozen years or so. The depth of his particular knowledge and experience, and his relationship with members of the media, are unique and invaluable, and I thank him sincerely.

## Special advisors

Stephen Bindman is a lapsed journalist – his words – of many years' experience, an adjunct professor at the University of Ottawa, and former lay benchler of the Law Society of Upper Canada. He was seconded to the Commission from the Department of Justice Canada, where he works as special advisor on wrongful convictions. As a journalist, his primary focus has always been on matters of judicial interest and he had covered several commissions of inquiry. Stephen was of great assistance to the Commission in organizing the drafting, editing, and production of this report as well as the policy roundtables.

Dale Craig, P. Eng., served as a special consultant to the Commission on engineering and architectural issues. He is chairman of the firm J.L. Richards and Associates Ltd. and enjoys a national reputation as an engineer, engineering consultant, and project manager, as well as for his community and professional engagement. His valuable guidance, advice, and evidence during the first phase of the Commission were essential. He was ably assisted by Laura Grover, P. Eng.

Nicolas deBreyne was seconded to the Commission as a civilian member of the Ottawa Police Service, with 18 years' experience in search and rescue and emergency management. He is an active member of a professional as well as a volunteer ground search and rescue team. He has participated in several hundred search and rescue missions, acting in such diverse roles as search manager and team leader in missing persons' searches and technical rescues. He is an internationally certified instructor in ground search and rescue as well as an accredited

instructor for all levels of the incident command system. His advice and expertise during Part Two of the Commission were of great value.

Section 11 of the Commission's Rules of Procedure provides that the Honourable Stephen Goudge of the Ontario Court of Appeal would (at the Commissioner's option) determine issues related to claims of privilege arising during the proceedings. I am particularly grateful that Mr. Justice Goudge immediately accepted this responsibility and for his determination of just such an issue during the course of the hearings.

## Office staff

All Commission personnel were ably assisted by the loyal and competent service of the Commission's office staff.

Line Lapointe and Jennifer Caissy ran the Elliot Lake office with great efficiency. In Ottawa, Jocelyne Geoffroy served as assistant to the executive director, and law clerk Sujethra Nadarajah handled numerous important tasks. Marie Burgher was a welcome addition to support staff during the report-writing stage. Jocelyne Shank from Borden Ladner Gervais, although not a formal member of the Commission staff, was an invaluable asset as we endeavoured to write the Report.

Durowaa Agalic, manager of operations and finance, diligently reviewed, processed, and followed up on the mountain of weekly invoices and kept the Commission updated on its budget forecasts and balances. Although she left the team early, it was for the best of reasons – she is now the proud mother of a baby girl.

Special mention is deserved for two individuals whose role before, during and, after the hearings was central. Kassandra Kuka, the Commission's document management clerk, managed the mountain of documents that formed part of the evidentiary foundation of the Commission and liaised with esi Specialists, the Commission's web-hosting and electronic data-processing specialists. Kassandra's good humour, expertise, and constant availability made this process seamless and relatively painless. Her name now appears countless times in the archived record of these proceedings followed by "Ms. Kuka, please call up document number ..."

Marc-André Bernard, my personal secretary and the Commission registrar, accomplished his role with great dignity and efficiency. In addition, he assumed the role of office manager of the Commission's Ottawa offices after the roundtables were completed.

I am indebted to the Ottawa Police Service for graciously permitting the secondment of two senior members of the force as investigators during the initial stages of the Commission. Det. Sabrina Corneanu and Sgt. Dan Simser ably conducted scores of interviews in preparation for the hearings and provided sound advice to Commission counsel.

The Commission was also assisted by the investigative services of retired Ottawa police officers Marc Pinault, Dan Desroches, and Douglas Handy.

The staff and administrators of the White Mountain Academy worked quickly and effectively to convert the spaces in the building into functional offices and a hearing room with appurtenant facilities for press, counsel, and the general public. Ongoing services and maintenance provided by Dennis Guimond in particular were of a high calibre.

All administrative and budgetary issues were coordinated through the Policy and Adjudicative Tribunals Division of the Ministry of the Attorney General, in particular Assistant Deputy Attorney General Irwin Glasberg and officials Earl Dumitru and Laureen Moran. Their support, quick responses to our questions, and respect for the independence of the Inquiry were commendable and greatly appreciated.



As I indicate above, the Commission hired esi Specialists to process its documents and host its documents in an online database. The service was so excellent that the main contact for the Commission, Yvette Bula (first of esi Specialists and then with SVR Litigation Case Management), quickly became an integral part of the team providing such case management services as tracking every detail of the documents being received and processed, searching for documents, and creating new fields to track all manner of items (e.g., briefs).

The Commission also relied heavily on the seasoned team of Wortzman Nickle for the initial screening of the documents.

During the hearings, the Commission hired Neeson & Associates Court Reporting and Captioning Inc. to provide real-time court-reporting services. The certified version of the day's transcripts was delivered and posted on our website at the end of each day.

Webmaster Djordje Sredojevic's (Autcon) previous experience with commissions of inquiry was telling. His work as the Commission's webmaster was most professional and responsive to our needs.

I was particularly impressed with the quality, professionalism and expertise of Avolution and its chief executive officer, Guy Bennett, in the technical planning and management of the audio-visual system, webcasting, and hearing room design at the White Mountain Academy. Justin Gray's constant expert assistance, helpful disposition, and advice ensured the smooth functioning of the system throughout the hearings. He has always gone beyond the duties that were normally assigned to him and was invaluable when the Commission experienced its electronic growing pains. From his perch at the back of the hearing room, he was always vigilant and anticipated most problems before they occurred. Excellent assistance was also provided by Paul Cotton, who replaced Justin for the last month of the hearings.

The physical production of a report such as this, especially one so complex and voluminous, is a massive undertaking. Luckily, we were guided at every step by Rob and Laura Herrera and the design gurus at H3Creative Inc. They are experts on all matters of font, spacing, and headings and have the ability to maintain their good cheer even when deadlines are missed. Our editors, Dan Liebman, Mary McDougall Maude, and Rosemary Shipton of Shipton McDougall Maude Associates, veterans of many similar inquiries, showed remarkable grace under extremely tight timelines. Our translators, Larrass Translations, met the challenge of converting in record time a very long and technical report in an accurate and easy-flowing French. I hope the result of all these efforts is a report that is both comprehensive and readable and easy on the eyes.

## Participants' counsel

Throughout the hearings, all counsel participated in a co-operative, highly professional, and dignified manner. With very few exceptions, potential areas of discord and conflict were easily resolved through intelligent and responsible discussion, negotiation, and common sense compromise. In the end, practical solutions were found to problems of substance and to problems of procedure without recourse to costly and time-consuming formal procedures. This collective sense of responsibility to achieve the ends of the Commission enabled proceedings to move along as smoothly as possible, without acrimony, spectacle-seeking, or futile squabbling, despite the existence of many competing interests. I note with pride that unlike many inquiries, none of these disputes ever landed in court to be resolved. For that and for the quality of their advocacy, this Commission is very grateful.

The Seniors Action Group of Elliot Lake (SAGE) was not represented by counsel. Its representatives (Keith Moyer and Chuck Myles), however, were granted one seat at the counsel table. Their active and intelligent participation as well as their sound and constructive advice were much appreciated. Similar comments are deserved by Ernie Thorne, representing the Elliot Lake Professional Fire Fighters Association (IAFF Local 1351); the Toronto Professional Fire Fighters Association (IAFF Local 3888); the Ontario Professional Fire Fighters Association (OPFFA);

and the International Association of Fire Fighters (IAFF). Mr. Thorne is not a lawyer, but his participation was both eloquent and effective.

## Community of Elliot Lake

I close by thanking the citizens of Elliot Lake. Their personal and collective sacrifices are recognized throughout this Report. This community, at the official and individual levels, has made me and all other members of the Commission feel welcome, appreciated, and at home here in their beautiful and unique city. We will not forget them.

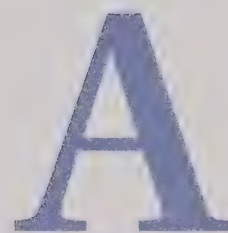
I was honoured to have been asked to lead this Commission of Inquiry.

I hope that the recommendations I have made will serve as a blueprint to ensure a tragedy like the collapse of the Algo Mall never occurs again.

## Notes

- <sup>1</sup> "McGuinty seeks inquiry into mall collapse; Bodies of two victims released to families," *Ottawa Citizen*, June 30, 2012, A6.
- <sup>2</sup> See Part One, chapter 1 (the section on Mandate).
- <sup>3</sup> Ontario, *Report of the Ipperwash Inquiry* (Toronto: Ontario Ministry of the Attorney General, 2007), vol. 3, 4–6 (Commissioner Sidney B. Linden).
- <sup>4</sup> Ontario, *Report of the Ipperwash Inquiry* (Toronto: Ontario Ministry of the Attorney General, 2007), vol. 3, 4 (Commissioner Sidney B. Linden).
- <sup>5</sup> Public Inquiries Act, S.O. 2009, C. 33, Schedule 6.
- <sup>6</sup> Transcript, October 26, 2012, p. 2.
- <sup>7</sup> SO 2009, c 33, Schedule 6.
- <sup>8</sup> RSO 1990, c P.41.
- <sup>9</sup> Commission counsel submissions, March 4, 2013, p. 17.
- <sup>10</sup> D. O'Connor, "The role of commission counsel in a public inquiry," *Advocates' Soc. J.* 22(1) (2003), 10.
- <sup>11</sup> Commission counsel submissions, March 4, 2013, p. 21; Commission counsel submissions, August 7, 2013, p. 19740.
- <sup>12</sup> Exhibits 92099–12.

- <sup>13</sup> Exhibits 9212, 9216.
- <sup>14</sup> Exhibit 9215.
- <sup>15</sup> SO 2009, c 33, Schedule 6.
- <sup>16</sup> Elliott submissions, April 19, 2013, p. 5814.
- <sup>17</sup> Commissioner Statement, April 22, 2013, pp. 6027–8; Commissioner Statement, April 24, 2013, pp. 6232–3.
- <sup>18</sup> Broadbent submissions, April 24, 2013, pp. 6516–8.
- <sup>19</sup> Broadbent submissions, April 24, 2013, pp. 6531–5.
- <sup>20</sup> Law Society of Upper Canada, effective November 1, 2000.
- <sup>21</sup> Commission counsel submissions, April 24, 2013, pp. 6538–9.
- <sup>22</sup> [1997] SCR 440.
- <sup>23</sup> *Canada (Attorney General) v Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1997] 3 SCR 440, para 55.
- <sup>24</sup> Canada, Commission of Inquiry into the Actions of Canadian Officials in Relation to Maher Arar. *Report of the events relating to Maher Arar* [vol.III]: *Analysis and Recommendations* (Ottawa: Minister of Public Works, and Government Services), 292–3 (Commissioner Dennis R. O'Connor).



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## Appendices





# Appendices

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## Appendix A – Key people in the emergency response

This lists sets out the names and relevant positions of some of the people who played a role in the emergency response to the collapse of the Algo Mall.

\*An asterisk indicates those who testified before the Commission

**Alamenciak, Henry**, chief, Emergency Medical Services, Algoma District

**Amyotte, Adam**, employee, Bargain Shop\*

**Aylwin, Lucie**, victim

**Aylwin, Rachelle**, mother of victim\*

**Aylwin, Réjean**, father of victim\*

**Baden, Greg**, world robotics leader

**Bailey, Dan**, constable, canine handler (Charlie and Dare), UCRT, OPP\*

**Bain, Trevor**, executive officer, Office of the Fire Marshal

**Barnes, Ken**, captain, Elliot Lake Fire Department

**Bartolucci, Rick**, minister of northern development and mines

**Bérubé, Yves**, eyewitness\*

**Bock, Jim**, staff sergeant, UCRT, OPP

**Booth, Art**, regional manager, Northeast Region, Office of the Fire Marshal

**Bradford, Dr. Marc**, coroner\*

**Bray, Natalie**, administrative assistant to the chief administrative officer, City of Elliot Lake\*

**Bruce, Robert**, chief superintendent, OPP\*

**Burns, Dale**, identification constable, OPP\*

**Burtenshaw, Kent**, HUSAR/TF3, Toronto Fire Department

**Carvalho, Avelino**, HUSAR/TF3, sergeant, Toronto Police Department

**Chambers, Carol-Lynn**, manager, Emergency Planning and Strategic Development, Office of the Fire Marshal, Ministry of Community Safety and Correctional Services\*

**Chanzy, Thomas**, chief of staff to minister of community safety and correctional services

**Châtelain, Patrick**, paramedic, UCRT, OPP

**Cleary, Peter**, employee, Ministry of Health and Long Term Care

**Codd-Downey, Beckie**, assistant to the premier, Office of the Premier

**Collett, Al**, councillor, City of Elliot Lake

**Collins, Chris**, constable, UCRT, OPP

**Comella, Tony**, team coordinator / leader, HUSAR/TF3, Toronto Fire Department\*

**Connors, Darren**, firefighter, Elliot Lake Fire Department\*



**Conrad, Debbie**, assistant deputy minister, communications, Cabinet Office

**Cox, Ryan**, constable, canine handler (Fuse), UCRT, OPP\*

**Cranford, James**, engineer, HUSAR/TF3, Stephenson Engineering

**Davidson, Ian**, deputy minister, Ministry of Community Safety and Correctional Services

**deBortoli, Bonnie**, scribe for Inspector Jollymore

**deBortoli, Robert**, chief administrative officer, City of Elliot Lake\*

**Demy, Paul**, HUSAR/TF3 driver

**Dennis, Sophie**, assistant deputy minister, Ministry of Labour

**Dolderman, Mike**, sergeant, USAR Command, UCRT, OPP

**Duerr, Coby**, assistant deputy fire chief, City of Calgary, Calgary Emergency Management, Canada Task Force 2\*

**Eady, Richard**, detective constable, OPP

**Ellen, Brent**, program specialist, Office of Fire Marshal

**Elliott, William**, firefighter, Elliot Lake Fire Department

**Esposto, Dan**, staff sergeant, OPP

**Ewald, Bruce**, chief building official, City of Elliot Lake

**Fabris, Antoine-René**, lawyer for Eastwood Mall

**Farquhar, Tom**, councillor, City of Elliot Lake

**Fay, Brian**, sergeant, OPP

**Feldman, Dr. Michael**, team doctor, HUSAR/TF3, Sunnybrook Centre\*

**Finamore, Sandy**, councillor, City of Elliot Lake

**Flood, Greg**, employee, Ministry of Community Safety and Correctional Services

**Fowlds, Scott**, canine search specialist (Ranger), HUSAR/TF3, sergeant, Toronto Police\*

**Freedman, Dr. Mark**, team doctor, HUSAR/TF3

**Gendron, Gary**, fiancé of victim\*

**George, David**, captain, Elliot Lake Fire Department

**Gillespie, Jamie**, sergeant, UCRT, OPP\*

**Glavin, Phil**, HUSAR/TF3, sergeant, Toronto Police Department\*

**Gryska, Alex**, director, Ontario Mine Rescue\*

**Guy, Chuck**, HUSAR/TF3, captain, Toronto Fire Department\*

**Hamilton, Richard**, mayor, City of Elliot Lake\*

**Hammond, Bradley**, associate press secretary, Office of the Premier

**Hefkey, Dan**, commissioner for community safety, Ministry of Community Safety and Correctional Services\*

**Hennessey, Darla**, responsible for social services on Community Control Group

**Howse, Dave**, program specialist, Emergency Preparedness and Response Unit, Office of the Fire Marshal

**Hulsman, Steve**, constable, UCRT, OPP\*

**Hume, Steen**, executive assistant, secretary to cabinet, Cabinet Office

**Jacklin, Wayne**, inspector, canine program coordinator / head trainer, OPP\*

**Jeffreys, Roger**, provincial engineer, Ministry of Labour\*

**Jenkins, Ronald**, deputy chief, Toronto Fire Service

**Jewitt, Don**, manager, Ministry of Labour

**Jollymore, Percy**, inspector, detachment commander, East Algoma Region, OPP\*

**Jones, Donald**, inspector, Ministry of Labour\*

**Kaderdina, Fahim**, chief of staff, Minister of Labour

**Kerr, Robin**, executive director, Victim Services of Algoma\*

**Killorn, Bill**, manager of legislative issues, Ministry of Labour

**Kluke, Danny**, firefighter, Elliot Lake Fire Department

**Kontra, Tom**, employee, Office of the Fire Marshal

**Labreche, Jocelyn**, employee, City of Elliot Lake

**Lacroix, Michel**, inspector, Ministry of Labour\*

**Latulippe, Darrin**, son-in-law of victim\*

**Law, Greg**, HUSAR/TF3, Toronto Fire Department

**Lawson, Jim**, HUSAR/TF3, sergeant, Toronto Police Department

**LeBlanc, Seirge**, press secretary, issues management, Minister of Community Safety and Correctional Services

**Lester, Craig**, HUSAR/TF3, Toronto Fire Department

**Livingstone, David**, chief of staff, Office of the Premier

**Mann, Norm**, councillor, City of Elliot Lake

**Mantha, Michael**, MPP for Algoma-Manitoulin\*

**Marceau, Jean-Marie**, eyewitness\*

**Matuszewski, Kate**, information officer, City of Elliot Lake

**McCallion, Michael**, site commander, HUSAR/TF3, Toronto Emergency Medical Services

**McCann, Wendy**, executive director of communications, Office of the Premier

**McDonnell, Dr. Michael**, team doctor, HUSAR/TF3

**McGuinty, Dalton**, premier of Ontario\*

**McRae, Martin**, HUSAR/TF3, training captain, Toronto Fire Department\*

**Meilleur, Madeleine**, minister of community safety and correctional services

**Miller, Laura**, deputy chief of staff, communications, Office of the Premier of Ontario

**Millett, Wayne**, firefighter, Elliot Lake Fire Department

**Mintz, Shayne**, assistant deputy fire marshal, Office of the Fire Marshal

**Morrissey, Jason**, eyewitness\*

**Muir, Dr. Craig**, regional coroner

**Neadles, William**, site commander, HUSAR/TF3, Toronto Police Staff Inspector\*

**Newburn, Dan**, employee, Office of the Fire Marshal

**Officer, Paul**, fire chief, Elliot Lake Fire Department\*

**O’Leary, John**, manager of legislative issues, Office of the Premier\*

**Oprici, Adam**, sergeant, OPP

**Ouimet, Christine**, media relations officer, OPP

**Parsons, Meshach**, sergeant, CBRNE Command, UCRT

**Pellerin, Ed**, detective sergeant, OPP

**Perizzolo, Teresa**, daughter of victim\*

**Perizzolo, Doloris**, victim

**Pollanen, Dr. Michael**, chief forensic pathologist for Province of Ontario

**Posen, Dr. Gerald**, retired nephrologist

**Priestly, Ryan**, president, Priestly Demolition Inc.\*

**Queen, Dr. Martin**, forensic pathologist, Health Sciences North\*

**Quinn, Natalie**, scribe for Chief Officer

**Rheume, Trudy**, emergency management coordinator, Elliot Lake Fire Department\*

**Rowland, Chris**, HUSAR/TF3

**Sanders, Brian**, regional engineer, Western Region, Ministry of Labour\*

**Selvers, Dave**, president, Millennium Crane\*

**Silver, Doug**, division chief, Toronto Fire Service

**Sobers, Tracy**, executive assistant to the premier, Office of the Premier

**Sorel, Don**, HUSAR/TF3, manager, Toronto Water, City of Toronto\*

**Strapko, Michael**, HUSAR/TF3, Toronto Fire Department

**Stuart, Allison**, chief of Emergency Management Ontario

**Taylor, Scott**, sergeant, Emergency Response Team Unit, OPP

**Thomas, John**, captain, Elliot Lake Fire Department\*

**Thorpe, Robert**, fire protection advisor, Office of the Fire Marshal

**Vance, Adam**, firefighter, Elliot Lake Fire Department

**Venter, Martinette**, owner of Shoppers Drug Mart and lottery kiosk in Mall

**Waddick, Patrick**, constable, UCRT, OPP\*

**Wallace, Peter**, secretary of the cabinet, Cabinet Office

**Webb, Kevin**, commander, OPP

**Weber, Paul**, constable, UCRT, OPP

**Wieclawek, Ted**, fire marshal

**Zammitt, Dave**, HUSAR/TF3, sergeant, Toronto Police Department



## Appendix B – Chronology of the emergency response

The following are some key events regarding the rescue and response to the Algo Mall collapse. The times identified are, for the most part, approximate.

### June 23, 2012

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<b>2:18 p.m.</b>	Collapse of the Algo Mall
<b>2:29–2:30 p.m.</b>	Arrival at the Mall of Captain John Thomas and Chief Paul Officer from Elliot Lake Fire Department
<b>2:34 p.m.</b>	OPP UCRT is mobilized
<b>2:49 p.m.</b>	Chief Officer activates Emergency Control Group
<b>3:00 p.m.</b>	Community Control Group (CCG) meeting to discuss declaration of an emergency
<b>3:04 p.m.</b>	First victim located
<b>3:26 p.m.</b>	Chief Officer contacts Office of the Fire Marshal and requests HUSAR/TF3
<b>3:28 p.m.</b>	Sign of life: communication with second victim is made by the Elliot Lake Fire Department
<b>3:45 p.m.</b>	HUSAR/TF3 advised of Elliot Lake collapse
<b>3:55 p.m.</b>	State of emergency declared by City of Elliot Lake
<b>4:20 p.m.</b>	Communication with victim is lost and second victim is located
<b>4:20 p.m.</b>	HUSAR/TF3 call-out begun
<b>4:42 p.m.</b>	Commissioner Dan Hefkey authorizes HUSAR/TF3 deployment
<b>5:46 p.m.</b>	Ministry of Labour provincial engineer sent to Elliot Lake
<b>6:00 p.m. and 7:15 p.m.</b>	Ministry of Labour inspectors sent to Elliot Lake to investigate collapse
<b>6:30 p.m.</b>	CCG meeting
<b>9:56 p.m.</b>	HUSAR/TF3 vehicles leave home of operations for Elliot Lake
<b>10:05 p.m.</b>	CCG meeting
<b>11:15 p.m.</b>	OPP contacts Millennium Crane

### June 24, 2012

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<b>12:30 a.m.</b>	Ministry of Labour provincial engineer arrives in Elliot Lake and surveys the damage
<b>4:18 a.m.</b>	HUSAR/TF3 arrives in Elliot Lake and conducts tour of collapse
<b>6:30 a.m.</b>	Cranes from Millennium Crane head to Elliot Lake
<b>8:00 a.m.</b>	CCG meeting

<b>9:00 a.m.</b>	City of Elliot Lake issues press release
<b>9:30 a.m.</b>	Sign of life: HUSAR/TF3 hears tapping noise
<b>11:15 a.m.</b>	165-tonne crane from Millennium Crane arrives in Elliot Lake
<b>11:30 a.m.</b>	Premier Dalton McGuinty speaks to Mayor Richard Hamilton
<b>12:00 p.m.</b>	CCG meeting
<b>12:10 p.m.</b>	Sign of life: indication of a live hit by HUSAR/TF3 dog Ranger
<b>12:28 p.m.</b>	Premier issues statement
<b>1:00 p.m.</b>	City of Elliot Lake issues press release
<b>3:45 p.m.</b>	60-tonne crane from Millennium Crane arrives in Elliot Lake
<b>3:57 p.m.</b>	CCG meeting
<b>4:40 p.m.</b>	City of Elliot Lake issues press release (possible casualty)
<b>5:00 p.m.</b>	City of Elliot holds press conference (possible fatality)
<b>Evening</b>	Premier speaks to MPP Michael Mantha
<b>7:50 p.m.</b>	Operation for removal of beam commences
<b>9:30 p.m.</b>	Sign of life: indication of live victim by UCRT dog Dare
<b>9:52 p.m.</b>	CCG meeting
<b>11:00 p.m.</b>	Rigging operation begins
<b>11:30 p.m.</b>	Sign of life: LifeLocator indicates live hit

## June 25, 2012

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<b>12:00 a.m.– 4:00 a.m.</b>	Rigging operation continues: SUV and slabs are removed
<b>4:00 a.m.</b>	HUSAR/TF3 dog Ranger deployed but no indication of sign of life
<b>5:00 a.m.</b>	UCRT dog Dare deployed and possible indication of deceased victim
<b>5:30 a.m.</b>	Sign of life: LifeLocator deployed and sign of breathing identified
<b>8:30 a.m.</b>	CCG meeting
<b>9:30 a.m.</b>	Devices made to measure the movement of the structure
<b>9:45 a.m.</b>	Workers ordered off site until engineering assessment completed
<b>10:45 a.m.– 11: a.m.</b>	Staff Insp. William Neadles and CCG advised of work stoppage
<b>12:00 p.m.</b>	Devices show movement and rescuers removed from site
<b>12:05 p.m.</b>	Press conference: public advised that situation is dangerous, but there have been signs of life and new approach being taken
<b>Before 2:00 p.m.</b>	Staff Insp. Neadles orders all responders withdrawn from building

<b>2:00 p.m.</b>	Fire Department and HUSAR/TF3 told the building is completely unsafe and no options available
<b>After 2:00 p.m.</b>	Rescue changes to recovery
<b>3:00 p.m.</b>	(CCG) meeting advised rescue is over
<b>6:00 p.m.</b>	Premier learns that rescue has been called off
<b>8:30 p.m.</b>	Premier asks responders to consider Plan B
<b>8:30 pm.</b>	CCG meeting
<b>10:20 p.m.</b>	Premier issues statement indicating that he has instructed the rescue team to determine if there is another way to reach the victims

## June 26, 2012

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<b>1:46 a.m.</b>	Priestly Demolition engaged
<b>6:00 a.m.</b>	Priestly mobilizes team
<b>9:00 a.m.– 10:00 a.m.</b>	Half of UCRT team is released
<b>10:21 a.m.</b>	Commissioner Hefkey arrives in Elliot Lake
<b>11:00 a.m.</b>	CCG meeting
<b>1:00 p.m.</b>	Press conference: Staff Insp. Neadles advises public of Plan B
<b>4:00 p.m.</b>	Ryan Priestly arrives in Elliot Lake and a rescue/recovery plan drafted
<b>5:00 p.m.</b>	CCG meeting
<b>6:00 p.m.</b>	Arrival on scene of Priestly high reach machine
<b>9:00 p.m.</b>	Demolition of the Mall begins in a controlled manner

## June 27, 2012

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<b>3:00 a.m.</b>	UCRT cadaver dog search is conducted on removed escalator outside Mall
<b>6:00 a.m.</b>	Demolition completed by Priestly
<b>6:00 a.m.</b>	UCRT cadaver dog search indicates two deceased
<b>6:50 a.m.</b>	Coroner arrives on the scene
<b>After 9:15 a.m.</b>	Doloris Perizzolo is recovered from the rubble
<b>1:34 p.m.</b>	Lucie Aylwin is recovered from the rubble
<b>Afternoon</b>	Premier visits Elliot Lake



## Appendix C – Schedule of witnesses – Part Two

<b>Adam Amyotte</b> , eyewitness	August 7, 2013
<b>Jean-Marie Marceau</b> , eyewitness	August 7, 2013
<b>Yves Bérubé</b> , eyewitness	August 7, 2013
<b>Jason Morrissey</b> , eyewitness	August 7, 2013
<b>Darrin Latulippe and Teresa Perizzolo (Perizzolo family)</b> , victim's family	August 7, 2013
<b>Rejean and Rachelle Aylwin (Aylwin family)</b> , victim's family	August 7, 2013
<b>Gary Gendron</b> , victim's fiancé	August 8, 2013
<b>Dan Hefkey</b> , Ontario's Commissioner for Community Safety, Emergency Management Ontario	August 8 & 9, 2013
<b>Dale Burns</b> , OPP identification constable	August 9 & 20, 2013
<b>Coby Duerr</b> , Assistant Deputy Fire Chief, City of Calgary, Calgary Emergency Management, Canada Task Force 2	August 15, 2013
<b>John Thomas</b> , firefighter, Elliot Lake Fire Department	August 15 & 20, 2013
<b>Darren Connors</b> , firefighter, Elliot Lake Fire Department	August 20 & 21, 2013
<b>Paul Officer</b> , Elliot Lake Fire Chief and incident commander	August 21, 22, 29, 2013 September 19, 2013
<b>Patrick Waddick</b> , constable, UCRT	August 23, 2013
<b>Robert Bruce</b> , chief superintendent, OPP	August 23, 2013
<b>Ryan Cox</b> , constable, UCRT	August 26, 2013
<b>Wayde Jacklin</b> , inspector, canine program coordinator/head trainer, OPP	August 27, 2013
<b>Daniel Bailey</b> , constable, canine handler, UCRT	August 27 & 28, 2013
<b>Steve Hulsman</b> , constable, UCRT	August 28, 2013
<b>Dr. Marc Bradford</b> , coroner	August 29, 2013
<b>Paul Officer</b> , Elliot Lake Fire Chief and incident commander	August 29, 2013
<b>Jamie Gillespie</b> , sergeant, UCRT	September 3 & 4, 2013
<b>Tony Comella</b> , team coordinator/ leader with the Toronto Fire Department, HUSAR/TF3	September 4, 5 & 6, 2013
<b>Michael McCallion</b> , site commander with Toronto EMS, HUSAR/TF3	September 6, 2013
<b>James Cranford</b> , engineer, Stephenson Engineering	September 9, 2013
<b>Dave Selvers</b> , Millennium Crane	September 9 & 10, 2013
<b>William Needles</b> , staff inspector, Toronto Police, Commander, HUSAR/TF3	September 10, 11 & 12, 2013

<b>John O’Leary</b> , former manager, legislative issues, Office of the Premier of Ontario	September 17, 2013
<b>Dr. Michael Feldman</b> , team doctor with the Sunnybrook Centre, HUSAR/TF3	September 18, 2013
<b>Carol-Lyn Chambers</b> , Ontario Fire Marshal	September 18, 2013
<b>Scott Fowlds</b> , sergeant, Toronto Police, HUSAR/TF3, canine unit	September 19, 2013
<b>Paul Officer</b> , Elliot Lake Fire Chief and incident commander	September 19, 2013
<b>Dr. Martin Queen</b> , forensic pathologist at Health Sciences North	September 20, 2013
<b>Alex Gryska</b> , Ontario Mine Rescue	September 23, 2013
<b>Michael Mantha</b> , MPP for Algoma-Manitoulin	September 23, 2013
<b>Percy Jollymore</b> , inspector, OPP	September 23 & 24, 2013
<b>Chuck Guy</b> , captain, Toronto Fire, HUSAR/TF3	September 24, 2013
<b>Martin McRae</b> , training captain, Toronto Fire, HUSAR/TF3	September 25, 2013
<b>Robin Kerr</b> , Victim Services of Algoma	September 25, 2013
<b>Donald Jones</b> , inspector, Ministry of Labour	September 26, 2013
<b>Trudy Rheame</b> , coordinator, Elliot Lake Fire Department	September 26, 2013
<b>Don Sorel</b> , Toronto Water, HUSAR/TF3	October 1, 2013
<b>Phil Glavin</b> , sergeant, Toronto Police, HUSAR/TF3	October 1, 2013
<b>Ryan Priestly</b> , president, Priestly Demolition Inc.	October 2, 2013
<b>Michel Lacroix</b> , inspector, Ministry of Labour	October 3, 2013
<b>Roger Jeffreys</b> , engineer, Ministry of Labour	October 3, 2013
<b>Dr. Gerald Posen</b> , retired nephrologist, former Chief of Nephrology at Ottawa Civic Hospital	October 4, 2013
<b>Brian Sanders</b> , regional engineer, Ministry of Labour	October 4, 2013
<b>Natalie Bray</b> , administrative assistant to the CAO, City of Elliot Lake	October 4, 2013
<b>Robert deBortoli</b> , chief administrative officer, City of Elliot Lake	October 7, 2013
<b>Richard Hamilton</b> , mayor, City of Elliot Lake	October 7, 2013
<b>Dan Hefkey</b> , Ontario’s Commissioner for Community Safety, Emergency Management Ontario	October 8, 2013
<b>Dalton McGuinty</b> , Former Premier of Ontario	October 9, 2013

## Appendix D – Policy roundtables – Part Two

To assist in formulating my recommendations, I convened a series of policy roundtables after the completion of the evidence and closing submissions. Each roundtable, chaired by a Commission counsel, consisted of a number of experts from those sectors that could be affected by my possible recommendations. The roundtables considered a series of questions prepared by Commission staff. These questions were also designed to reflect the recommendations made by Participants in their closing submissions. Listed below are the date, moderator, roundtable participants, and topics for the Part Two roundtables, followed by biographies of the participants.

### THURSDAY, DECEMBER 5, 2013

**Moderator: Mark Wallace**

#### **Participants:\***

- Richard Boyes, Ontario Association of Fire Chiefs
- Scott Campbell, Ontario Ministry of Labour
- Eva Cohen, Liaison Officer, German Federal Agency for Technical Relief (Technisches Hilfswerk)
- Assistant Deputy Chief Coby Duerr, Calgary Fire Department
- Insp. Mark Ford, Ontario Association of Chiefs of Police
- Alex Gryska, Ontario Mine Rescue
- Deputy Commissioner Vince Hawkes, Ontario Provincial Police
- Chief John Hay Thunder Bay Fire Rescue (representing Northwestern Ontario Municipal Association)
- Commissioner Dan Hefkey, Ontario Commissioner for Community Safety
- Stuart Huxley, Association of Municipalities of Ontario
- Deputy Chief Ronald Jenkins, Toronto Fire Services, Project Leader, Heavy Urban Search and Rescue Team
- Benjamin Morgan, City of Calgary, supervisor of crisis communications
- Matt Pegg, Ontario Association of Fire Chiefs
- Basia Schreuders, International Association of Emergency Managers – Canadian Council
- Insp. (retired) Lance Valcour, Canadian Interoperability Technology Interest Group
- Ted Wiclawek, Fire Marshal of Ontario and Chief of Emergency Management Ontario

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\* Positions are as of the time of the participation



## ROUNDTABLE 1 – ISSUES RELATING TO THE CONDUCT AND MANAGEMENT OF AN EMERGENCY RESPONSE

1. IMS-related issues:
  - (a) How can Incident Management System be made more understandable and simpler, and still achieve its purposes?
  - (b) Should Incident Management System be required in emergency management–related legislation?
  - (c) Should Ontario use the same Incident Command System as other jurisdictions in North America?
  - (d) Should elements of Incident Management System be mandatory? If so, what elements should be mandatory?
    - (i) Incident Action Plans
    - (ii) Planning Operation / Planning Cycle
    - (iii) Communications
    - (iv) Debriefing
  - (e) Can the terminology involved be clarified and expressed in simpler terms (e.g., Incident Commander)?
  - (f) Should there be a requirement for a preliminary reconnaissance by someone either on the scene or who can be transported there quickly (i.e., by air, especially where the scene is remote from Toronto so planning can begin immediately)?
2. Organization of Search and Rescue Teams
  - (a) What is the role of the Provincial Government in managing, and being responsible for, search and rescue resources?
  - (b) Within the Provincial Government, which department(s) / agency(ies) should be responsible for managing search and rescue assets?
  - (c) Should the Ontario Provincial Police and the Office of the Fire Marshal manage discrete search and rescue resources?
3. Decentralized Emergency Management
  - (a) Does the model of “bottom-up response,” established by the *Emergency Management and Civil Protection Act* and its regulations, need to be refined?
  - (b) Are communities adequately supported by the Province?
  - (c) Is there adequate oversight of local preparedness, such as emergency management plans and related training?
  - (d) Should the Province have responsibility for dealing with specific roles, such as media relations?
  - (e) Should teams, such as Incident Support teams used in the United States, be considered in the Ontario emergency management structure?

#### 4. Clarity in the relevant legislation

- (a) Should the *Occupational Health and Safety Act*, its regulations, or policies related to it specify the powers of Ministry of Labour inspectors in an emergency?
- (b) How can the powers and authority of the Ministry of Labour at a rescue / recovery be clarified?  
How can the manner in which those powers should be exercised be clarified?
- (c) Do any laws need amendment in order to allow responders to access and remove bodies located on private property?

#### 5. Directory of Vital Services

- (a) Should emergency response–related entities be required to maintain a directory of emergency-related vital services such as heavy equipment and lumber?
- (b) What vital services should be required to be included in such a directory?

### **ROUNDTABLE 2 – ISSUES RELATING TO THE ENTITIES THAT MAY RESPOND TO AN EMERGENCY**

#### 1. What should be the future of the Province's urban search and rescue resources?

- (a) Is there a role / requirement for a heavy search and rescue team?
- (b) Should there be more medium and/or light teams?
- (c) Where should they be located?
- (d) What should be the expertise and capabilities of these teams?
- (e) How should sites far from Toronto, especially in Northern Ontario, be accessed more quickly?
  - (i) Can other entities, such as Ontario Mine Rescue, be integrated into the current emergency response structure, at least in some areas of the province?
  - (ii) Can federal assets, such as cargo transport planes, be deployed?

#### 2. Deployment of search and rescue assets

- (a) How can it be assured that sufficient personnel are deployed to particular emergencies?
- (b) How can it be assured that sufficient personnel are deployed with training in specialized areas such as rigging and planning?
- (c) Can response time be improved? Is six hours the best possible mobilization time that can be expected for a heavy team?

#### 3. Jurisdiction / Command and Control

- (a) When more than one entity responds to an emergency, how should command and control operate? (i.e., who should be in charge?)
- (b) Should there be a more specific command structure within individual entities and between different entities (e.g., the command structure within TF3 and the command structure between TF3 and UCRT)?

#### 4. Consistency in Response

- (a) Should there be greater consistency in training standards among emergency-related entities?
- (b) Should emergency-related entities train together more frequently?
- (c) How can uniformity in communications (e.g., radio communications) be improved? This question addresses communications (e.g., radio communications) among responders, as well as consistency in communications between elements of the response apparatus (Community Control Group, responders, and the province), the media, and the public.
- (d) How can terminology used by different emergency-related entities be more consistent (e.g. incident commander, action plans)?

#### 5. Role of Engineers

- (a) Should search and rescue teams be required to have a structural engineer as part of their team?
- (b) What should be the role of a structural engineer in a rescue involving a collapsed or partially collapsed structure?
- (c) Who should fill the role of engineer in such incidents (MOL, private industry)?
- (d) Where should the engineering resources be located?

#### 6. Equipment and Expertise

- (a) Are there gaps in equipment that is accessible by emergency-related assets?
- (b) Are there gaps in the training related to heavy equipment?
- (c) If so, how can those gaps be filled?



Roundtable participants, sitting, from left: Alex Gyska, Matt Pegg, Eva Cohen, Dan Hefkey; standing, from left: Stuart Huxley, Insp. Mark Ford, Deputy Chief Ronald Jenkins, Assistant Deputy Chief Coby Duerr, Deputy Commissioner Vince Hawkes, Richard Boyes, Basia Schreuders, Chief John Hay, Benjamin Morgan, Insp. (retired) Lance Valcour, Scott Campbell, Ted Wieclawek (PHOTO: Matt Copeland)



## BIOGRAPHIES\*

**Richard Boyes** has been the executive director of the Ontario Association of Fire Chiefs (O AFC) since November 2012. He has served on the board of directors for 11 years, three as president. In 2009 he played a key role in working with the Government of Ontario to include the 19,000 volunteer firefighters in the presumptive illness legislation. In addition, he was responsible for a number changes to regulations at the Ministry of Transportation which improved fire protection in Ontario. With more than 40 years' experience in the fire service, he has held positions as fire chief in Alliston, Sarnia, and, most recently, Oakville. He worked with the Office of the Fire Marshal as a fire service advisor, and was chair of the Transportation Emergency Rescue Committee for the International Association of Fire Chiefs. He is a certified municipal manager III and fire service executive as well as a community emergency management coordinator.

**Scott Campbell** is manager of the Ministry of Labour's Emergency Management Program. He consults with internal and external stakeholders, providing expertise in the application of best safety practices and the *Occupational Health and Safety Act* during emergencies. He has instituted a public education campaign that integrates the ministry's prevention mandate by promoting safety as a component of emergency planning, and is collaborating on the development of foreign animal disease and pandemic response plans. In 2013, he evaluated an audit of the provincial emergency management program and made recommendations on how to address its findings. Since joining the ministry in 2004, he has also been a program manager, Industrial Health and Safety Program, in Mississauga and Hamilton; a provincial specialist with the Occupational Health and Safety Branch; and an occupational health and safety inspector / provincial offences officer.

**Eva Cohen** grew up in Germany and studied at the University of Regensburg. Before moving to Canada, she was an active member of German Federal Agency for Technical Relief, Technisches Hilfswerk (THW), a national volunteer disaster relief organization. She is a certified search and rescue canine team leader and also trained her own dog to be an INSARAG-certified search and rescue dog. She has been active in promoting the concept of a nation-wide volunteer-based emergency response organization in Canada modelled on the THW, and she is the THW liaison officer for Canada. The THW is the only national disaster relief organization based almost entirely on volunteers. She is currently working with the City of Ottawa Office of Emergency Management and the County of Renfrew Emergency Services to establish a volunteer emergency response pilot project.

**Assistant Deputy Chief Coby Duerr** began his firefighting career in Naramata, British Columbia, then moved into a resident position within Penticton's fire service. He joined the Calgary Fire Department in 2000, took on a position with the Heavy Rescue technical team, and later became the task force leader of Canada Task Force 2 (CAN-TF2) – a position he holds today. His time in CAN-TF2 resulted in the program entering a growth phase that culminated in a provincial-level deployment to the Slave Lake fires in 2011. He was then promoted to the role of emergency management coordinator for the City of Calgary and, while working at the Calgary Emergency Management Agency (CEMA), was involved in many large-scale incidents. Following his promotion to assistant deputy chief in April 2013, he continued his work with CEMA and was assistant Emergency Operations Centre manager during the devastating floods of 2013. In October 2013, he was transferred to the position of assistant deputy chief of operations and technical teams for the Calgary Fire Department.

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\* Positions are at the time of the roundtables.

**Inspector Mark Ford** has 26 years' experience with the Ottawa Police Service (OPS). He is currently the inspector in charge of Emergency Operations Support. A past member of the executive of the National Incident Commanders Working Group Association, he teaches Critical Incident Command at the Canadian Police College and sits on the Emergency Management committees of the Canadian Association of Chiefs of Police and the Ontario Association of Chiefs of Police. He spent 11 years with the Tactical Unit and Explosives Unit. During this time, he also specialized in the area of CBRNE response and was an original member and later chair of the National CBRNE Response Working Group. He championed the introduction of the Incident Management System within the OPS. For four years as a duty inspector, he was an incident commander for a number of critical incidents and major events. In 2011, he was seconded along with Chief Charles Bordeleau to the Independent Review of the Vancouver Stanley Cup riots to prepare a technical report on police planning and management.

**Alex Gryska** is a certified occupational health and safety technologist with the American Board of Industrial Hygiene and the Board of Certified Safety Professionals. He gained his industrial experience at the Kerr Addison and at Macassa mines, where he worked in various departments including production, geology, ground control, ventilation, and safety. He had a lengthy career with the Ontario Ministry of Labour, working in various capacities including inspector, special investigations officer, training coordinator, mediator-advisor, regional program advisor, and district manager. He has been associated with mine rescue since 1975, when he first became an active volunteer. He is the director of Ontario Mine Rescue and has been responsible for the program since 2001. He led Ontario Mine Rescue through a program review and helped transform it into the world-calibre organization it is today, with more than 875 active mine rescue volunteers.

**Deputy Commissioner Vince Hawkes** was appointed Ontario Provincial Police deputy commissioner in August 2006. In November 2010, he took over responsibility for the OPP Field Operations Command, which encompasses the operational activities of five OPP regions, as well as the Aboriginal Policing Bureau and approximately 4,500 personnel. Previously, he served as provincial commander of Investigations and Organized Crime, which included responsibility for specialty services and criminal investigations. He spent 11 years as a forensic specialist and was the first OPP member to be certified as a bloodstain pattern analyst. He has also been commander in numerous positions within the OPP. He is the past chair for the Canadian Integrated Response to Organized Crime, a multi-service partnership; a member of the International Association of Chiefs of Police; and a director with both the Canadian Association of Chiefs of Police and the Ontario Association of Chiefs of Police.

**Chief John Hay** of Thunder Bay Fire Rescue (TBFR) has 30 years' experience with Thunder Bay Fire Rescue. He is certified as a Paramedic 1, Haz Mat, Technical Rescue Technician. Other certifications include Incident Management System 300, Incident Management System 910, Incident Command System Level 4, and Incident Management System 250 for the Emergency Operations Centre. He has experience in large-event exercise planning and is an Urban Search and Rescue team leader. He and the TBFR are members of the provincial Chemical, Biological, Radiological-Nuclear and Explosives (CBRNE) Program. Chief Hay is a member of the Fire Marshal's Advisory Committee and the Fire Marshal's Public Safety Council. Among recent events where he served as incident commander or area commander were the 2013 First Nation flood evacuation, the 2012 Thunder Bay flood, the 2011 forest fire evacuation at Sandy Lake, and the 2010 G8 Summit in Huntsville.

**Dan Hefkey** is Ontario's Commissioner for Community Safety. He joined the Ontario public service in 1984 as a police officer with the OPP. In 1995, he was among the first OPP officers to participate in the United Nations Civilian Policing mission to Haiti. On his return from Haiti, he joined a team that examined the state of emergency preparedness within the OPP. Following that project, he worked on the development of an initiative that resulted in the creation of the Emergency Management Bureau, where he became the operational planner for the OPP. In January 2007, he was appointed to the post of chief of Emergency Management Ontario. In October 2008, he was promoted to assistant deputy minister responsible for emergency management and business continuity, while retaining the position and responsibilities for Emergency Management Ontario. In January 2011, he was appointed commissioner for community safety, responsible for the overall accountability of public safety strategies.

**Stuart Huxley** is senior legal counsel with the City of Ottawa. He was called to the Ontario bar in 2000, and has worked exclusively as counsel to the City of Ottawa since 1998. He leads the city's Prosecution Unit and has extensive prosecution experience with regulatory matters, including the *Building Code*, the *Fire Code*, and the *Planning Act*, as well as various municipal by-laws before the Ontario Court of Justice. Mr. Huxley also practises municipal law and litigation before the Superior Court of Justice and has represented the city on significant matters before coroner's inquests, the Divisional Court, the Court of Appeal for Ontario, and the Supreme Court of Canada. He is also actively involved in the City's emergency management and preparedness program. He represented the Association of Municipalities of Ontario.

**Deputy Fire Chief Ronald Jenkins** has 33 years' experience as a chief officer with Toronto Fire Services and currently holds the position of deputy fire chief. He has also served as a volunteer district chief with the Georgina Fire Services for the past 22 years and holds various designations, among them Canadian municipal manager III; fire suppression professional and fire executive from Canadian Municipal Management; and chief fire officer from the Canadian Association of Fire Chiefs. As well, he has served extensively on Toronto Fire Services Heavy Urban Search and Rescue (HUSAR) Team/CAN TF3 – formerly as team lead and currently as project leader. He also works with the City of Toronto (COT) Office of Emergency Management and is part of the Emergency Management Working Group. He is currently the program director of the COT Chemical, Biological, Radiological, Nuclear-Explosives (CBRNE) Program.

**Benjamin Morgan** is a communications professional with 10 years' expertise in public and media relations, issues management, and crisis communications. As the City of Calgary's supervisor of crisis communications, he played an integral role in that city's communication response to the 2013 flood. He is currently participating in a targeted investment project with the Canadian Department of National Defence, Social Media in Emergency Management. During his 16 years as an advanced life support paramedic, he served as the public and media relations officer for the City of Calgary Emergency Medical Services, appearing regularly on local and national television, on radio, and in print media. In 2009, he founded Both Sides Media Consulting Group, a communication consulting agency that offers strategic communication, media relations consulting, and training primarily to Calgary's not-for-profit sector.



**Deputy Chief Matt Pegg** is currently president of the Ontario Association of Fire Chiefs and deputy fire chief for the City of Toronto. He has been involved with the Ontario Association of Fire Chiefs in various roles since 2009, including as director, treasurer, and vice-president. He has also been a member of the Technical Committee of the National Fire Protection Association. He has been a member of the Fire Service since 1992. Before assuming his current position as deputy fire chief for the City of Toronto, he served in that role for the City of Brampton, the Town of Ajax, and the Town of Georgina. He is a former member and co-chair of the Fire Service Advisory Committee to the Ontario Minister of Labour. He has a broad educational background in public management, industrial relations, fire service administration, and fire service leadership.

**Basia Schreuders** is co-chair of the Government Affairs Committee of the International Association of Emergency Managers – Canadian Council. She has emergency management experience in chemical, biological, and radiological and nuclear hazards; public health emergencies; security; and natural disasters. She is also a certified emergency manager. From 2009 to 2011, she was the chief of the Federal Government Health Portfolio Operations Centre, which was the hub of the health response to events such as the Vancouver 2010 Olympic Games and the G8/G20 Summits. She previously owned an emergency management consulting firm that worked closely with the Department of Foreign Affairs, Trade and Development and developed the Canadian foreign mission emergency plans and co-designed pilot software. Ms. Schreuders has volunteered in the Disaster Planning and Response Division of the American Red Cross of Greater New York, where she designed, coordinated, and facilitated emergency exercises related to natural disasters and shelter operations. She is now an advisory committee member for the graduate certificate in emergency management and teaches emergency operations centre management at Algonquin College in Ottawa.

**Inspector (Ret.) Lance Valcour** retired from the Ottawa Police Service in 2010 after 33 years of service. He now works for the Canadian Association of Chiefs of Police, Fire and Emergency Medical Services, holding the post of executive director of the Canadian Interoperability Technology Interest Group. Inspector Valcour has extensive experience, at both the national and the international levels, in communications interoperability, incident command, leadership, strategic planning, and technology program management. He works co-operatively with national and international strategic organizations, such as the Canadian Association of Chiefs of Police Information and the Communications Technology Committee, often in the information-sharing and public safety interoperability fields. He is on the board of the National Public Safety Telecommunications Council, and in October 2013 became chair of the board for the Law Enforcement Information Management Section of the International Association of Chiefs of Police.

**Tadeusz (Ted) Wieclawek** was appointed fire marshal of Ontario in January 2011 and chief of Emergency Management Ontario in August 2013. He is the leader of the Office of the Fire Marshal and Emergency Management, a division of the Ontario Ministry of Community Safety and Correctional Services formed in August 2013 to merge the Office of the Fire Marshal and Emergency Management Ontario. He first joined the Office of the Fire Marshal (OFM) in 1992 and, over the years, progressed through the ranks. He played an integral part in the policy and legislative development of the *Fire Protection and Prevention Act, 1997* (FPPA). During his career, he contributed to the development of risk management tools and programs to help municipalities to determine appropriate levels of fire protection services and the OFM to monitor the delivery of those services across the province in accordance with requirements set in the FPPA.

## Appendix E – List of appearances for Participants with standing and witnesses – Part Two

Participant	Counsel/Representative
The International Association of Fire Fighters (IAFF) The Ontario Professional Fire Fighters Association (OPFFA) The Elliot Lake Professional Fire Fighters Association, Local 1351, I.A.F.F. The Toronto Professional Fire Fighters Association, Local 3888, I.A.F.F.	Ernie Thorne Secretary - Treasurer Ontario Professional Fire Fighters Association
Ontario Association of Fire Chiefs	John W. Saunders Carolyn L. McKenna Brad Bigrigg <b>Hicks Morley Hamilton Stewart Storie LLP</b>
James Cranford and Stephenson Engineering Ltd.	Robert E. Hutton <b>Brown Beattie O'Donovan LLP</b>
Seniors' Action Group of Elliot Lake (SAGE)	Keith Moyer
The Elliot Lake Mall Action Committee (ELMAC)	Peter L. Roy Carolyn Filgiano Alexandra Carr <b>Roy O'Connor</b> Roland Aubé <b>Aubé Law Office</b> Jeff Broadbent <b>Feifel Broadbent Gualazzi</b> Douglas Elliot <b>Douglas Elliott PC</b> Shawn Richard
City of Elliot Lake	Paul Cassan Steven Shoemaker Matthew Shoemaker Alexandria Little <b>Wishart Law Firm LLP</b>
City of Toronto	Richard Oliver <b>City of Toronto Legal Services</b>
Former Premier Dalton McGuinty and John O'Leary	J. Thomas Curry Nadia Campion <b>Lenczner Slaght</b>
Government of Ontario	Ken Hogg Darrell Kloeze Norm Feaver Heather Mackay Kristin Smith Judith Parker <b>Ministry of Attorney General</b>
Dr. Michael Feldman	Paul Erik Veel <b>Lenczner Slaght</b>

## Appendix F – Order in Council



### **BACKGROUNDER**

Ministry of the Attorney General

#### **Order in Council**

*On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:*

WHEREAS under the Public Inquiries Act, 2009, S.O. 2009, c. 33, Sched. 6, the Lieutenant Governor in Council may appoint a person to inquire into any matter of public interest;

AND WHEREAS Lucie Aylwin and Doloris Perizzolo tragically died and a number of other individuals were injured as a result of the collapse of the Algo Centre Mall in the City of Elliot Lake, Ontario;

AND WHEREAS it is considered desirable and in the public interest to establish an independent process to examine the circumstances surrounding the collapse of the Algo Centre Mall and the emergency management and response subsequent to that collapse;

AND WHEREAS it is considered advisable to set out the terms of reference for such a process;

THEREFORE, pursuant to the Public Inquiries Act, 2009:

#### **Establishment of the Commission**

1. The Honourable Paul R. Bélanger is appointed effective July 20, 2012 a Commissioner.

#### **Mandate**

2. Having regard to section 5 of the Public Inquiries Act, 2009, the Commission shall:
  - a. Inquire into and report on events surrounding the collapse of the Algo Centre Mall in Elliot Lake, Ontario, the deaths of Lucie Aylwin and Doloris Perizzolo and the injuries to other individuals in attendance at the mall and the emergency management and response by responsible bodies and individuals subsequent to the collapse;
  - b. Review relevant legislation, regulations and by-laws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the structural integrity and safety of the Algo Centre Mall in Elliot Lake, Ontario;
  - c. Review relevant legislation, regulations and by-laws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the emergency management and response to the collapse of the Algo Centre Mall in Elliot Lake, Ontario.
3. The Commission shall perform its duties without expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization. The Commission shall further ensure that the conduct of the inquiry does not in any way interfere or conflict with any ongoing investigation or proceeding related to these matters.



4. Where the Commissioner considers it essential and at his discretion, he may engage in any activity appropriate to fulfilling his duties, including:

- a. Conducting research and collecting information, including conducting interviews and undertaking surveys;
- b. Conducting inter-jurisdictional research to identify practices and successes in other jurisdictions that are relevant to the Ontario experience;
- c. Consulting with or seeking submissions from key stakeholders and sector experts;
- d. Consulting with the general public, including consulting prior to making its rules or determining who may participate in the public inquiry; and
- e. Receiving oral and written submissions.

5. The Commission shall, as much as practicable and appropriate, refer to and rely on the matters set out in section 9 of the Public Inquiries Act, 2009.

6. Pursuant to section 14 of the Public Inquiries Act, 2009, the Commission shall hold public hearings as necessary to fulfill its mandate and may exercise the powers provided for in section 13 of the Public Inquiries Act, 2009.

### **Resources**

7. The Attorney General shall, in consultation with the Commission, set a budget for the conduct of the public inquiry. The Attorney General may, in consultation with the Commission, establish fees and rates of pay for persons engaged by the Commission.

8. In engaging the services of lawyers to act as its counsel, clerks, reporters and assistants, and other persons having special technical or other expertise or knowledge or in obtaining other services and goods it considers necessary in the performance of its duties, the Commission shall follow Management Board of Cabinet directives and guidelines and other applicable government policies unless, in the Commissioner's view, it is not possible to follow them.

9. All ministries and all boards, agencies, and commissions of the government of Ontario shall, subject to any necessary privilege or other legal restrictions, assist the Commission to the fullest extent possible, including producing documents in a timely manner, so that the Commission may carry out its duties.

10. The Commission shall promote accessibility and transparency to the public through the use of technology, including by establishing and maintaining a website.

### **Funding**

11. The Commission may make recommendations to the Attorney General regarding funding to participants in the inquiry, to the extent of that participant's interest where, in the Commissioner's view, the participants would not otherwise be able to participate in the inquiry without such funding. Such funding shall be in accordance with applicable Management Board of Cabinet directives and guidelines.

**Report and Recommendations**

12. The Commission shall endeavour to deliver a final report containing its findings, conclusions and recommendations to the Attorney General within 12 months, but in any event no later than 18 months, after the commencement of the inquiry.

13. During the course of its work, the Commissioner shall convey to the provincial government for its immediate consideration any interim measures the Commissioner identifies that, in his opinion, could be adopted that might improve any matters falling within its mandate.

14. The Commission shall be responsible for translation and printing and shall ensure that the final report is delivered in both English and French in electronic and printed versions and available in sufficient quantities for public release.

15. The Attorney General shall table the report with the Legislature and make the report available to the public.

## Appendix G – Order in Council extension



Ontario

Executive Council  
Conseil exécutif

### Order in Council Décret

On the recommendation of the undersigned, the Lieutenant Governor, by and with the advice and concurrence of the Executive Council, orders that:

Order in Council numbered O.C.1097/2012 and dated July 19, 2012, and pursuant to which the Honourable Paul R. Bélanger was appointed a Commissioner, be amended effective the date this Order in Council is approved and ordered by replacing paragraph 12 as follows:

12. The Commission shall deliver a final report containing its findings, conclusions and recommendations to the Attorney General no later than October 31, 2014.

Recommandé par : Le procureur général,

Recommended

Attorney General

Approuvé et décrété le

Approved and Ordered

DEC 04 2013

Date

Sur la recommandation de la personne soussignée, le lieutenant-gouverneur, sur l'avis et avec le consentement du Conseil exécutif, décrète ce qui suit :

Le décret numéro 1097/2012 pris le 19 juillet 2012, conformément auquel l'honorable Paul R. Bélanger a été nommé commissaire, est modifié le jour de l'approbation et de la prise du présent décret par remplacement de la disposition 12 par ce qui suit :

12. La commission remettra au procureur général son rapport final comportant ses constatations, conclusions et recommandations au plus tard le 31 octobre 2014.

Appuyé par : Le président du Conseil des ministres,

Concurred

Chair of Cabinet

Le lieutenant-gouverneur,

Lieutenant Governor



## Appendix H – Commission personnel

### Commissioner

The Honourable Paul R. Bélanger

### Commission Counsel

J. Bruce Carr-Harris, Senior Counsel

Peter K. Doody, Senior Counsel

Mark Wallace, Senior Counsel

Nadia Effendi, Associate Counsel

Nadia J. Authier, Associate Counsel

Nigel Marshman, Associate Counsel

Duncan A.W. Ault, Associate Counsel

Natalia Rodriguez, Associate Counsel

Ivana Nenadic, Student-At-Law (August 21, 2012 – June 20, 2013)

### Administration

Suzanne Labbé, Executive Director

Jocelyne Geoffroy, Administrative Assistant (September 4, 2012 to December 16, 2013)

Durowaa Agalic, Manager, Operations & Finance (October 5, 2012 to November 7, 2013)

Marc-André Bernard, Office Manager, Registrar and Assistant to the Commissioner

Kassandra Kuka, Document Management Clerk (September 12, 2012 to October 15, 2013)

Sujethra Nadarajah, Law Clerk (November 1, 2012 to October 11, 2013)

Line Lapointe, Administrative Assistant and Registrar (November 1, 2012 to October 9, 2013)

Jennifer Caissy, Administrative Assistant (February 25, 2013 to October 4, 2013)

Marie Burgher, Administrative Assistant (May to July 2014)

### Advisors

Dale Craig and Laura Grover, J.L. Richards and Associates Ltd., Engineering Consultants

Stephen Bindman, Special Advisor to the Commissioner

Nicolas deBreyne, Search and Rescue Specialist (November 27, 2012 to December 6, 2013)

Kyle Lambert, Special Assistant to Counsel (June to September 2013)

Sgt. Dan Simser, Investigator (September 21, 2012 to January 31, 2013)

Cst. Sabrina Corneanu, Investigator (September 4, 2012 to February 28, 2013)

Ivana Nenadic, Special Assistant to Counsel (September 16, 2013 to August 2014)

**Media and Communications**

Peter Rehak, Director of Communications

**Webmaster**

Autcon: Djordje Sredojevic

**Document Review and Classification**

Wortzman Nickle

**Document Management**

ESI Specialists

Yvette Bula, Steve Bula,

SVR Litigation Case Management

**Inquiry Webcast**

Avolution Multimedia

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Paul Cotton

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Helen Martineau

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Claude Bordeleau

Joseph Caron

Yves Lalonde

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**Report Production**

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**Translation**

Larrass Translations

**Printers**

TRICO evolution

# Appendix I – Inquiry statistics

## Evidentiary hearings

First day of hearings



Last day of hearings



Hearing days



Number of witnesses  
(some testified in both parts)



Participants with standing  
Part One



Participants with standing  
Part Two



Total number of  
documents collected



Approximate number  
of exhibits filed

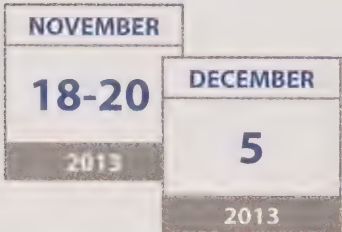


Pages of  
transcript (approximate)



## Policy roundtables

Dates



Number of days



Number of participants





## Appendix J – Letters and statements

### J.1 – Letter from Commissioner Bélanger to the residents of Elliot Lake

**August 1, 2012**

To the Residents of Elliot Lake:

I have been appointed as Commissioner of a public inquiry into the collapse of the Algo Centre Mall which caused the deaths of Lucie Aylwin and Doloris Perizzolo and injuries to a number of other individuals on June 23, 2012. I am also asked to inquire into the emergency management and response to this event. My Commission will review all relevant laws, regulations, by-laws, policies, processes and procedures relating to these two aspects of the inquiry. We will eventually report our findings and make recommendations to the Government of the Province of Ontario in the hope that this type of tragedy does not occur again.

The Commission considers it important that it hear from the residents of Elliot Lake about the impact of this tragedy on their lives and the community as a whole. One of the ways to do this is for the Commission to have an informal initial meeting with the residents. It seems to me that understanding the scope of the impact upon the residents will provide a foundation for further avenues of investigation and inquiry.

I have scheduled Wednesday, August 15th for the initial community meeting at 9:30 a.m. at the Lester B. Pearson Civic Centre. What I would like to do at the initial meeting is to introduce myself and the core members of my Commission, explain in general terms what we propose to do and invite questions from you. Then, we would like to hear from individual residents with respect to the impact this matter has had upon them. Individuals will be given the opportunity to come forward and speak about the impact this has had on their lives or to express their thoughts in writing. They may do so in public or in private.

At the more formal public hearings which will begin early in the New Year in Elliot Lake, the Commission will look into the causes that gave rise to this tragedy and to the emergency response. Prior to those hearings, those wishing to apply for standing will be given an opportunity to do so. Standing at a public inquiry gives a person or organization the right to participate in the proceedings, receive access to documents and examine and cross-examine witnesses. Participation in the earlier community hearings will not foreclose participation in the more formal hearings.

Some of you may be concerned that the formal hearings will not commence earlier. Let me explain that a tremendous amount of organizational and investigative work needs to be done before we can hold formal hearings. Large amounts of materials need to be gathered and analyzed. Witnesses and other individuals must be interviewed. Offices must be set up, facilities must be identified in Elliot Lake to hold hearings and to accommodate us. Notices to parties must be given with appropriate lead time. Rules of procedure must be developed. Standing hearings must be held. The list of things to do is daunting and complex. I hope that you will understand.

If you wish to speak at the public hearing or wish to meet me privately, you may communicate with me as follows:

Mr. Justice Paul R. Bélanger

The Courthouse, 6<sup>th</sup> Floor judges' chambers

161 Elgin Street

Ottawa Ontario

K2P 2L1

E-mail: [info@elliotlakeinquiry.ca](mailto:info@elliotlakeinquiry.ca)

Fax : (613) 239-1506

A free 800 number will be provided as soon as possible.

I recognize that some of the residents may have sought legal advice about what has occurred. I do not want to interfere with that process in any way. However, it would be most useful to the Commission to hear from the people directly affected at the informal community meeting I have discussed above.

Yours very truly

Paul R. Bélanger

## J.2 – Address of Commissioner Bélanger to the residents of Elliot Lake

### August 15, 2012, at the Lester B. Pearson Community Centre in Elliot Lake

Ladies and Gentlemen – Good morning.

I'll be repeating my comments in French at the conclusion of these remarks – je répèterai mes commentaires en français à la conclusion de ceux en anglais.

My name is Paul Bélanger and I have been appointed by the Government of the Province of Ontario as Commissioner for the Commission of Inquiry into the collapse of the Algo Centre Mall.

I begin by expressing my condolences and that of my colleagues to those of you who have lost loved ones, cherished friends or neighbours on the 23rd of June last. Indeed this tragedy shook all Ontarians as well as the people of Canada. We are concerned about those of you who were injured as well as those who have been impacted by the collapse – financially, emotionally, and socially.

It is that tragedy that brings us here today.

Our immediate concern today and tomorrow is not HOW or WHY this tragedy happened - that will come later as our investigation progresses and as we hold public hearings.

We are here now because we want to hear from you on the IMPACT that the events of 23 July and following days has had upon you. We wanted to come here as soon as possible so that you know who we are - so that we know who you are. We want to listen to you, the citizens of Elliot Lake. Hearing your stories will help us focus our work here. It will put faces and voices of real people to what are otherwise dry facts we read about in the media.

Those of you who want to speak publicly about their experience can come up to the microphones and talk to us. Those who want to speak privately to us will have an opportunity to do so this afternoon and tomorrow. Some of you may have questions. We will try to answer them.

We are taking this opportunity to get to know Elliot Lake, to tour the site of the collapse and to speak to responsible groups and individuals, such as the members of your chamber of commerce and your elected officials.

Let me explain to you what a Commission of Inquiry is and what it isn't. A public inquiry investigates and reports on matters of substantial public interest to a community. A public inquiry is not a trial. No one is charged with any criminal offence and no one is being sued. As Commissioner, I have no right to find any one guilty of a criminal offence nor can I establish civil responsibility for damages. Inquiries tend to be broader than either criminal or civil trials and, as a rule, while they investigate past events, they tend also to be concerned with providing an explanation of what happened so as to assist in preventing similar events in the future. But I want to emphasize that there are no legal consequences from the commissioner's findings. This distinction can be frustrating for members of the public who want to see perceived wrongdoers penalized. Punishment or penalty may well follow, but not as part of the public inquiry itself.

A public inquiry also needs to be both public and available to the public and I am committed to having open and public hearings. That is why we are here today and why our public hearings will be here in Elliot Lake. For the convenience of parties, some parts of the hearings such as applications for standing and funding (these occur before the actual public hearings) may have to be off-site; we will be making efforts to have these proceedings broadcast live. Indeed, we are exploring ways and means to have all hearings televised live so that if you can't



attend in person, you can watch from a remote location either in real time or by re-broadcast. At the hearings, we will be setting up a media room so that interested journalists can accurately report on what has gone on. One of our counsel has been designated as our media spokesperson to give timely explanations to the media about the Commission and to make materials as accessible as possible to them.

We have already set up a website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca). And we will be making efforts to ensure that it is always up to date so that everyone can follow our progress.

I invite as many of you as possible to attend our hearings when they commence and to follow us on television and on the web site.

I want to emphasize that these initial meetings with you and others in public and in private will not constitute evidence in our inquiry. For the sake of transparency and the appearance of fairness, the private meetings will be audio recorded in an anonymous way so that speakers are not identified. They will be confidential and not released to anyone unless it is on direct order from me and only if it should be shown to be in the public interest. However, if you object to recording, we will refrain from doing so.

I repeat and emphasize that the purpose of this informal meeting is to allow us to appreciate what you have lived and are still living through.

Now, let me introduce those who are here with me this morning. Commission counsel plays a vital and critical role in a public inquiry. They are the legal arm of the inquiry. Essentially, I am their client – their only client. The main responsibility I have given them is to represent the public interest at the inquiry. They do not represent a particular point of view, as they might if this was a legal case in court. They are not prosecutors. Their role is not adversarial nor do they take one side over another. They have a duty to make sure that all issues bearing on the public interest are brought to my attention. Their job is to use their skills and experience to present all of the available relevant evidence in as fair and thorough a fashion as possible.

Mr. Bruce Carr-Harris is a recognized expert in construction litigation among other specialties and a decorated leader of his profession.

Mr. Peter Doody is a highly experienced litigator in public, administrative and commercial law.

Mr. Mark Wallace is a highly experienced criminal law specialist.

All three have extensive and varied experience as counsel in public inquiries.

Ms. Nadia Effendi is fluently bilingual, a gold medal graduate in law and a specialist in civil and public litigation.

Other counsel have already joined or will be joining the legal team.

Mr. Peter Rehak – our media consultant – has already spent time here in Elliot Lake in the last few weeks setting things up. Peter has acted as media consultant for virtually all commissions of inquiry in Ontario for the past dozen years and we are grateful to have a man with his wealth of journalistic experience and wisdom as part of our team.

On our website you will find short biographies of all of the key members of the Inquiry.

Let me conclude by saying that public commissions of inquiry are an important component of a mature and democratic society such as ours – they play a key role in fact finding, informing the public and making recommendations to ensure that the matter that is the subject of the inquiry does not occur again. They may also play a role in restoring public confidence in government institutions.

Above all, if they are to be effective and receive cooperation, commissions must be perceived as being completely fair to all. That will be one of this commission's overriding objectives. In addition, we want to be thorough. We want to be efficient, accessible and cost effective.

You're going to be seeing a lot of us over the next year. Our investigators will be gathering information so that we can begin obtaining the materials we need and identifying the persons we need to speak to. All I ask for from you is your cooperation, understanding and assistance.

I will now turn over proceedings to Mr. Bruce Carr-Harris who will answer questions on behalf of the commission.

### J.3 – Opening remarks of Commissioner Bélanger at the hearing on standing and funding

Elliot Lake, October 26, 2012

#### CHECK AGAINST DELIVERY

Good morning and welcome to the first formal session of the Elliot Lake Inquiry. My name is Paul Bélanger – I am a retired judge of the Ontario Court of Justice and I have been appointed Commissioner of this independent inquiry.

Thank you all for coming this morning.

It is a pleasure to be back here in Elliot Lake.

As you may recall, my team and I were here in August to meet informally with the residents of Elliot Lake to hear directly from them about the impact that the events of June 23 and following days had on them.

We met publicly and privately with approximately 40 individuals.

I can tell you we all left with a clear understanding of how emotional the issues we are investigating are to this community, and the absolutely devastating impact the collapse of the Algo Centre Mall has had on the people of Elliot Lake and surrounding community. As we continue our work, we will most certainly keep these sentiments in mind and remember the two citizens who perished in this tragedy.

I think it is important to reiterate what I said in August about the role of a public inquiry – what it is and what it isn't. **A public inquiry investigates and reports on matters of substantial public interest to a community. A public inquiry is not a trial. No one is charged with any criminal offence, nor is anyone being sued. A public inquiry must be conducted with scrupulous fairness and impartiality.**

I am pleased to report that much has been accomplished since we were last here:

- I have assembled a full team of lawyers, investigators and support staff to assist in our work. I can assure you they are highly skilled and devoted to the important work ahead. You met our lead counsel at our August session. Information about the rest of the team is on our website.
- We have set up offices here in Elliot Lake and in Ottawa where I and my counsel are based and we are nearing completion of the hearing room at the old White Mountain Academy of the Arts that has not been in use for some years. We will have seating for the public there, and it will also be possible to view the proceeding on a large screen elsewhere in the Academy. I understand that the city library, Service Canada and some other institutions are also setting up at the Academy. As I indicated in August, all of our proceedings will be broadcast live on the Internet. The local cable company is looking at the possibility of broadcasting the proceedings as well and we are setting up a media room so that local, regional and national media can cover the proceedings.
- We have secured accommodations for my team when we move up here for the hearings which I hope will begin early in the new year.

The first part of our work involves conducting our own investigation into the issues that I have been directed to inquire into. **I must emphasize, however, that our investigation is separate from any of the other investigations currently underway into this tragedy.** To this end:

- We have served summons on more than 60 individuals, companies and organizations to obtain documents relevant to our investigation.



- We have so far received approximately 73 500 documents and my team is diligently reviewing and sifting through them.
- My investigators have already interviewed approximately 50 people and expect to interview many more in the coming days.

As well, we have published our Rules of Standing and Funding and Rules of Procedure. They are on the Commission's website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca). Each public inquiry establishes its own rules. We have drafted our Rules in a way that makes sure that the process we plan to follow is open, transparent and fair to everyone involved. We've also tried to write the rules in plain language.

Once I have determined which parties have standing, we will be inviting comments and suggestions about the rules.

So while much has already been accomplished, clearly there is a great deal of work still ahead of us. I am mindful of the July 20 order-in-council establishing the Commission, which directs me to report within 18 months.

I wish to assure you and all the people of Ontario that my staff and I are keenly aware that we are spending taxpayers' money and we will ensure that we will conduct these hearings – and all our work – in a manner that is fair to all involved, efficient and respectful of the current economic climate.

But we have been appointed by the Government of Ontario to get answers to this tragedy – and we will get those answers. The answers are of course important for the people of this community – but they are also important for all the people of Ontario to ensure another tragedy like this does not occur.

Just one final point.

While important aspects of our mandate require me to inquire into the events surrounding the collapse of the Mall and the emergency management and response to it, I have also been directed to review legislation, regulations and practices relating to the structural integrity of buildings and emergency management generally.

I have yet to devise the exact mechanisms through which we will deal with that aspect of the mandate.

As Madam Justice Arbour said in her report on The Prison for Women, the "highly structured form of inquiry (i.e. the formal hearings) would be inappropriate and costly in helping the Commission with its ... major task of making policy recommendations."

She undertook a separate process for that purpose that had a less structured format and relied on the "free exchange of views by invited experts and interested parties, but it did not rely upon formal submissions and the services of legal counsel."

Some commissions have carried out their policy reviews through the creation of expert panels; others through round tables. Others still have invited experts to provide written submissions.

May I take this opportunity to invite all counsel to discuss with Commission Counsel your views on how we can best achieve this policy objective.

While our primary focus until now has been the gathering of information, I have also asked Commission Counsel to research best practices in other jurisdictions in areas such as professional qualifications, construction engineering and inspection and emergency response. When that information has been collected and properly edited, I propose to make it available to all participants in this inquiry. I look forward to your collaboration on this important aspect of our work.

The purpose of today's hearing is to determine who will have standing to participate in the work of the Commission. The test for standing is whether the person or organization has a "substantial and direct interest" in the work of the Commission. Those persons or organizations granted standing can take an active part in the proceedings of the inquiry.

In addition, I will, as previous commissions have done, consider the following:

- The nature of the party's interest and proposed involvement in the inquiry;
- Whether the party has an established record of concern for, and a demonstrated commitment to, the interest it seeks to represent;
- Whether the party has special experience or expertise with respect to the Commission's mandate;
- Whether the party can reasonably be included in a group with others of similar interests.

As you will see from the Rules we have published, we have divided our work into two phases – one dealing with events prior to the collapse of the Mall on June 23, 2012, and the other dealing with events on and after that date.

While of course these are not iron-clad compartments, they will help us to better organize our work. Some groups or individuals, therefore, may receive standing and/or funding for one phase and not necessarily the other.

Based on the written submissions I have received, I have already indicated that I did not require a number of applicants to appear today.

Today I will hear brief submissions from those who have been invited to attend.

On the issue of funding, I must emphasize that my mandate only permits me to make recommendations to the Attorney General on which groups or individuals should receive funding for their participation in the work of the Commission. The test is whether these individuals or groups "would not otherwise be able to participate in the inquiry without such funding."

[Submissions of Applicants]

Thank you for all your submissions.

I will release as soon as possible my ruling on who will receive standing and my recommendations on who should receive funding.

I'm not yet in a position to announce the date for the start of the public hearings. Before we begin, we have to be sure that we have gathered all the information, that we have interviewed all those who may be helpful, and that we have organized everything for the hearings, so that this information can be presented in an understandable and efficient way.

All this takes time. However, my hope is that we will be in a position to start the hearings early in the new year. I encourage you to check our website regularly or updates about the Commission's schedule and events.

Thank you all for coming today.

## J.4 – Commissioner Bélanger’s update to residents of Elliot Lake

### January 2013

To the Residents of Elliot Lake

Happy New Year!

I am writing to give you an update on the work of the Elliot Lake Commission of Inquiry.

Much progress has been made since I was appointed in July to inquire into the collapse of the Algo Centre Mall.

The team of lawyers, investigators and professional staff that I have assembled share my commitment to discover the causes of this tragedy and make recommendations to prevent similar tragedies in the future.

We have been working at full speed to gather the information and documents we need before we can proceed with public hearings.

We have served summonses on more than 100 individuals, companies and organizations to obtain documents relevant to our investigation.

We have so far received approximately 280,000 documents and my team is diligently reviewing, categorizing and classifying them. A substantial number is still outstanding, however, and that gives me cause for concern if we are to complete our work within the time period stipulated in our mandate.

My investigators have already interviewed approximately 250 people.

I must emphasize, however, that our investigation is separate from any of the other investigations currently underway into this tragedy.

In October, I held a hearing in the community to hear applications for standing and funding. I granted standing to 14 individuals and organizations and recommended that the Ontario government provide funding to three groups.

In December, I held a hearing in Ottawa on two requests to keep certain documents confidential and issued my ruling this week.

Our hearing room at the former White Mountain Academy of the Arts is finally nearing completion. To that end, I am pleased to announce that the Commission’s public hearings are expected to begin in the week of March 4, 2013, assuming the hearing room is ready and we have received all the documents we have summonsed and are necessary for the hearings. Our present plan is to sit four days a week.

I was hoping to start our hearings a few weeks earlier but the scope of the preparatory work, including construction of our hearing room and offices, was greater than originally anticipated. However, experience at other inquiries has shown that detailed preparations have usually paid off in more compact, well-organized and efficient public hearings.

There will be seats in the hearing room for members of the public who wish to observe the proceedings and an overflow room equipped with a large television screen.



All of our proceedings will be broadcast live on the Internet. The local cable company is looking at the possibility of broadcasting the proceedings as well and we are setting up a media room so that local, regional and national media can cover the hearings.

I look forward to meeting some of you during the course of the hearings.

I know that 2012 was a very difficult year for many in the community, but one cannot help but be impressed by the strong sense of community, courage, dynamism and hope as the citizens of Elliot Lake work together to rebuild a vibrant and safe town center. I am confident that 2013 will be a great year for Elliot Lake!

Paul R. Bélanger  
Commissioner

## J.5 – Commissioner Bélanger's opening statement – Part One (March 4, 2013)

Ladies and gentlemen – mesdames, messieurs

Good morning - bonjour

Welcome to this the opening session of the public hearings of the Elliot Lake Commission of Inquiry

Je vous souhaite la bienvenue à cette première session des audiences publiques de la Commission d'enquête sur Elliot Lake.

Je répèterai mes commentaires en français lorsque j'aurai terminé en langue anglaise.

As you know, my name is Paul Bélanger and I am a retired judge of the Ontario Court of Justice. On July 19th 2012, I was appointed by the Government of the Province of Ontario to be the Commissioner of this Inquiry. We have been mandated to look into the causes of the collapse of the Algo Centre Mall and the emergency management and response that followed, to examine legislation, regulations and practices in effect at the time of the collapse as well as to make recommendations to the Government with a view to ensuring that this sort of tragedy does not occur again.

The terms of reference of the Inquiry can be found on the Inquiry's web site at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca) as is other important information about our work.

Every Commission of Inquiry has to invent itself from scratch. Administrative and legal staff must be found. Facilities need to be rented and fully equipped, from staplers to large photocopiers, from pencils to computers.

This Commission's work is made doubly difficult because of the relative remoteness of Elliot Lake where the closest commercial airport is over 2 hours away, either in Sudbury or in Sault Ste. Marie and driving distance from large centers such as Ottawa or Toronto are 7-8 hours away in the best of weather conditions. On a number of occasions during the past few months, teams of lawyers dispatched to interview witnesses have had to return, their mission unaccomplished, because of inclement winter weather.

In addition, the Commission has had to navigate carefully in order not to interfere with ongoing police investigations, as well as investigations by the Ministry of Labour, the Professional Engineer's Association and the Coroner's office. In some respects, we can work cooperatively and in parallel with these organizations, but this must be done carefully, considering the differing and often divergent legislative and policy mandates of each.

We set up offices in Ottawa while overseeing at the same time the construction of this impressive hearing facility (the White Mountain Building) here in Elliot Lake with offices and spaces for staff, counsel, interpreters, press, etc., servers for our computing system and the all of the electronic equipment that you see set up in this hearing room.

We've implemented a document retrieval and coding system, as well as a document sorting and evaluating system, all electronic, to ensure that all documents that are relevant to the Commission's mandate are made available to all participants and eventually to the public when the most important ones are made exhibits.

We have set up a website to inform all participants and the public of the work of the Commission and signed a contract for a stenographic/recording/monitoring system so that transcripts of proceedings are available to the

participants and to the public who wish follow the proceedings of the Commission. We are striving to ensure that rough transcripts of the day's proceedings are available on our Web site soon after the end of the sitting day.

We continue to experience some difficulty with bandwidth for receiving and transmitting electronic information to and from this facility, but I am hopeful that the situation will be regularized this week when the promised optical cable is finally hooked up. The video quality of the live broadcasting of proceedings to our website may be somewhat diminished initially but we have been assured that we will see a marked improvement before week's end. In addition, Eastlink Cable will be providing coverage but with a delay.

And of course, an entire logistical apparatus has had to be developed so that Commission staff and counsel can be accommodated and transported while they live here in Elliot Lake and do their work. Much of the credit for doing that work in an efficient and cost effective way goes to Ms. Suzanne Labbé, our Executive Director. We are providing simultaneous translation of all the proceedings to ensure that everyone can follow the Commission's business in both official languages.

There is additional seating in the overflow room located on the ground floor so that persons not able to find a seat in the hearing room or who are unable to get to the second floor of the building can follow proceedings on a large screen T.V. As well, the Commission has set up a large media room to make it easier for journalists to cover the hearings.

I've just described the highlights – the minutiae behind those highlights are mind-boggling.

Some of you will have met Commission counsel, most of who are here today. Bruce Carr-Harris, Peter Doody and Mark Wallace are senior Commission counsel. Nadia Authier, Nadia Effendi, Natalia Rodriguez and Duncan Ault are Associate counsel. Ivana Nenadic is our articling student and Nigel Marshman remains in our offices in Ottawa along with Stephen Bindman who among other tasks will coordinate the writing of our eventual report. Their biographical notes are on our website. Also present are Suzanne Labbé, our executive director and Peter Rehak who is our media relations expert. He has occupied that role with distinction in many of Ontario's recent Commissions of Inquiry to ensure that the public, through the press and our website, is kept fully informed of our work and our progress. Responses to requests for information will be handled by Peter as well as by senior Commission counsel and Ms. Nadia Effendi in French.

I would also like to introduce you to two other people you will be seeing a lot of – our clerk-registrar Marc-André Bernard and Kassandra Kuka, our document technician who will ensure the timely and efficient retrieval of all important documents.

Commission counsel have been extremely busy and diligent in the past few months inventorying, classifying and determining the importance and relevance of mountains of documents that we have received as a result of the summonses issued since September. They and their investigators have interviewed hundreds of potential witnesses, have prepared overview statements, witness will-say statements and assembled the document briefs that witnesses receive prior to their testimony. I touch only briefly on the breadth and depth of their work. It continues apace by some, as others participate in the public hearings.

It bears repeating that this Commission does not exist to lay the foundation for criminal charges or civil liability. This is not a trial. I do not have the intention nor the authority to make any legal determination. The strict rules of evidence that govern in a court of law do not apply. The Commission makes its own rules, in consultation with the participants. As I have said, we are here to determine why this tragedy happened, how the emergency response and management was carried out and how things might be improved to prevent repetition.

Perhaps the most important aspect of our mandate is to ensure that we proceed openly, fairly and transparently. This, after all, is the public's inquiry.



To help us in this process, quite a number of individuals and organizations have been granted standing. Many of them are here today represented by counsel. In addition, I have recommended funding for some of them and so far, the Government has accepted all of my funding recommendations.

There will be two distinct phases to the evidentiary part of the Inquiry. First, we shall attempt to determine the causes of the collapse and study the legislation, regulations, policies and practices that had been in effect until that event. That requires, of course, that we go back in time to the late '70s and chart the evolution of standards over the four decades of the Algo Mall's existence. The second phase of the Inquiry will look at the facts and the policies underlying the search, rescue and recovery effort that followed the collapse. Finally, once the evidentiary process has concluded, we anticipate seeking the assistance of experts, using roundtables as the inquiry model, to obtain the most current information and advice pertaining to subjects that will have arisen through the public hearing process.

As we go forward in this endeavour, I am very conscious of the necessity of the process being cost effective. It must also be highly efficient if we are to remain within the 18 months allocated to us by our Order in Council. Those two requirements are challenging, considering the narrow timelines and distances involved and the complexities of the problem we are asked to resolve.

We welcome input from participants at any time regarding our process and any constructive suggestions on how to make it more streamlined and efficient.

At this time, I would ask all counsel to introduce themselves. I invite your brief opening comments or statements.

Once we have heard from counsel, we will break for remainder of the day to allow for further familiarization with the equipment, to permit interaction between counsel, to iron out potential difficulties, discuss schedules etc.

We will begin hearing evidence tomorrow commencing at 9.30 a.m. After this week, I anticipate we will sit four days a week, from Monday to Thursday next week and from Tuesday to Friday the week following. This will allow for a four-day weekend every two weeks in order that all have an opportunity to attend to other business.

We will have 20-minute health breaks at a convenient time both in the morning and afternoon sessions. Lunch break will be between 12.45 and 2 p.m. Sessions will begin at 9.30 a.m. and should end around 4.30 p.m. These times will be flexible, of course.

My hope is that this process will proceed smoothly and cooperatively with the ultimate object always in view.

So, we are ready to begin and I call first upon Commission Counsel, Mr. Peter Doody.

## J.6 – Statement of Commissioner Bélanger regarding Stated Case (March 19, 2013)

1. On February 4, I issued an Order pursuant to s. 29 of the *Public Inquiries Act, 2009* requiring Bob Nazarian, Irene Nazarian, and Levon Nazarian to comply with summonses I issued on Sept. 6, Sept. 13, Sept. 27, and December 6, 2012.
2. On March 5, counsel retained by me contacted counsel for the Nazarians and advised him that she had been retained to state a case to the Divisional Court under s. 30 of the statute, the contempt provisions.
3. On March 6, 2013, I issued Reasons for my Order of February 4. Those Reasons, and the Order of February 4, can be found on the Commission's website.
4. On March 7, 2013, the Notice of Application for a Stated Case was issued at the Divisional Court. The Court assigned a hearing date of March 20.
5. On March 8, 2013, counsel for the Nazarians caused to be delivered to the data management firm retained by the Commission approximately 85,000 emails which were from certain email addresses referred to in one or more of the summonses.
6. These emails are not all relevant to the Commission's work; they will be reviewed electronically to produce potentially relevant emails. Those emails so identified will be screened for relevance by a law firm retained for that purpose by the Commission. After that review, the documents which are relevant will be provided to Commission counsel for review, unless the screening law firm concludes that a particular email or emails may be potentially subject to a legal privilege. This is the same process which has been followed with respect to other documents obtained pursuant to summonses issued by the Commission where the custodian of the documents was unable to review the documents for relevance and potential privilege in a timely manner.
7. Those potentially privileged emails will be provided to the Nazarians' counsel for review so that they may determine whether to assert a claim that any of the emails are privileged. The Nazarians have agreed, through counsel, that if they do not assert a claim to privilege in accordance with the Commission's Rules of Procedure within 7 days, accompanied by supporting sworn evidence, they will be deemed to have waived any privilege associated with any email.
8. On March 12, 13, and 15, the data management firm retained by the Commission was provided with financial information sought in the summonses to the Nazarians.
9. On Friday, March 15, my counsel was provided with a sworn affidavit from each of Bob, Irene, and Levon Nazarian which set out in detail the steps taken by them to comply with the summonses. In each of those affidavits, the deponent swore that he or she was not in possession or control of any other document described in any of the summonses. A copy of each of those affidavits has been posted to the Commission's website.
10. Each of the Nazarians has also provided the Commission with a signed direction to the Canada Revenue Agency directing that agency to provide income tax information to the Commission.
11. In light of the above, I have instructed my counsel to advise the Divisional Court that my application to state a case is being discontinued, without prejudice and without costs.

## J.7 – Commissioner Bélanger's statement on first anniversary of collapse (June 14, 2013)

As you know, this will be the last sitting day of the Commission before we resume on the 8th of July next.

It is during this three-week hiatus, the three-week break, that the one-year anniversary of the tragedy of 23 June, 2012, will occur. Much has happened here in Elliot Lake since that sad event, and the progress made since then speaks volumes about the resilience and about the courage of the people of Elliot Lake. It is encouraging to watch the new mall slowly rise up just a block away from the remains of the Algo Mall.

And yet despite the intensity with which the community tackles the rebuilding process, we can't forget the loss of innocent lives, the injuries, the financial losses and hardships and the disruptions which have been caused by the collapse of the Algo Mall.

I know that the residents of this City will mark the anniversary at 2:19 p.m. on the 23rd of June with a moment of silence and the release of balloons with messages attached to them. Fittingly, this ceremony is entitled "Remembering Together."

And while I and other members of the Commission will be physically absent over the next three weeks, I can assure you that the Elliot Lake tragedy and the senseless deaths of Doloris Perizzolo and Lucie Aylwin will be very much on our minds on the 23rd of June next at that time of the day wherever we physically may be.

We have been working very hard since our appointment last summer, and this will be our first break since we started hearings on March 4th. We need this break so that all participants, including Commission staff and Counsel, can attend to family and personal concerns back home and prepare for the second phase of our hearings.

I take this opportunity to thank all members of the Commission, Counsel, staff and technical support, for the wonderful support they have given me. Their energy and devotion to duty has truly been exceptional.

And I also want to thank Counsel and representatives of the Participants for their valuable contribution to the effective and efficient work of the Commission, and to our translators, our court reporters and countless others who have assisted us in this massive undertaking. And most of all, I would like to thank the residents of Elliot Lake for making us feel so welcome in this home away from home.

I believe we have made significant progress on the mandate assigned to us by the Government of the Province of Ontario. I think we now certainly have a clearer picture of the history of this troubled mall and some of the factors that may have led to its collapse.

We have sat so far for 62 days. We have called 62 witnesses. More than 6,400 exhibits have been filed, and we have spoken for tens of thousands of pages of transcript.

Clearly, the volume of materials and the number of witnesses has been much greater than even we had originally anticipated. But obviously, we have got a lot of work ahead of us. We hope to have Part One of the hearings complete by the end of July so that we can start with Part Two, the search and rescue portion, in early August.

When we complete that phase, policy roundtables will follow, and while we are focussing at the moment on fact-finding in the past, we will certainly also be considering recommendations for the future to ensure, to the extent that that is possible, that no such tragedy is repeated in the future.

For those of you who will be taking this opportunity during the break to enjoy some summer holidays, I wish you all sunshine and fair winds and, after we close today, I'll see you again on the 8th of July.



## **J.8 – Commissioner Bélanger’s opening statement – Part Two (August 7, 2013)**

After five months of hearings into the causes of the collapse of the Algo Centre Mall on June 23rd of last year, we begin with the second phase of the hearings, the emergency management and the response to the collapse.

We will have to interrupt these hearings next week for three days to hear Participants’ oral submissions in relation to Phase One. I expect that this phase of the hearings will take up all of August and September of this year, to be followed then by policy roundtables in Ottawa in early October and, if we haven’t had an opportunity to hear them, to hear final submissions on Phase Two, following the roundtables.

As proceedings unfold in Phase Two, this phase that we are embarked upon, certain aspects of the evidence may be upsetting and may be traumatic to certain observers. I’ve asked Commission counsel to be alive to this possibility, and to warn me and to persons watching, both on television and present in the hearing room, that such evidence is about to be presented so that appropriate warnings can be given.

Similarly, I ask counsel for the Participants to be sensitive to this aspect of the evidence as they conduct their questioning and then alert me to the possibility of that occurring if that does occur.

## **J.9 – Commissioner Bélanger’s closing statement – Part Two (October 9, 2013)**

And now then, ladies and gentlemen, the evidence-gathering portion of this Inquiry, as you all know, is at an end, and this is after seven and a half months of nearly continuous hearings.

And all that is left now in relation to Part Two is to hear the submissions of counsel and of the Participants, to hear the oral submissions on the 12th of November. Roundtables of experts on various subjects that flow from the evidence we have heard will be held in Ottawa for seven days in late November and early December.

And I want you to know, I want the public to know, that the roundtables will be broadcast live on our website. People in Elliot Lake will be able to view the discussions on the 55-inch screen already mounted in the cafe room on the entrance level of this, the White Mountain Building. And counsel and members of the public will have an opportunity to ask questions of the panelists via telephone or via e-mail, and specific details will be posted in due course on our website.

Now the decision to hold the roundtables in Ottawa rather than Elliot Lake relates principally to costs which would have been prohibitively high had we decided to have all of those expert participants come here to Elliot Lake.

The next task that awaits us is the drafting of the report. Commission staff and I must review and analyze the evidence of 125 witnesses, spread over 117 days, reported on 28,900 pages of transcript, of the hundreds of thousands of documents obtained by the Commission through its processes, very close to or – and I think Ms. Kuka gave me the number this morning – 11,053 have now been made exhibits.

I want to thank Commission counsel for their energy and devotion to this arduous and daunting duty. I would not do them justice by attempting to describe the bewildering amount of work entailed in marshalling and presenting the evidence we have heard.

What we have all observed in this the hearing room is but the tip of a monumental iceberg of work. With the exception of one short break this summer, they have adhered to a punishing schedule from 9:00 to 5:00 every day, and not one evening, not one single evening or weekend has passed since we first arrived here on Spine Road without a substantial number of them being here well into the evening preparing the next day’s work or the next week’s witness. I will say more about them in our Report.

And similar comments apply to our staff left behind in Ottawa under the direction of our Executive Director Suzanne Labbé who has been indefatigable and very patient.

I thank our hearing room staff, Marc-Andre Bernard, our registrar, Cassandra Kuka, our document technician, our stenographic professionals, and our technical specialists represented by Paul up there for ensuring a relatively seamless and problem-free proceedings.

And I also thank the White Mountain administration and personnel. Those who have worked on previous commissions have all commented on the superlative quality of these premises. They are the best they have seen, and the public and the press have been well accommodated in the hearing room, the press room, and the overflow room in the cafe room downstairs. The only comment I have heard, the only complaint I have heard is that the hearing room benches were a little too hard. But there may have been a method to that reality.

I’m grateful to our Media Relations Officer, Mr. Peter Rehak, whose depth of experience has ensured a smooth relationship with all media representatives.

I thank Counsel for, and representatives of the Participants, for their professionalism, their cooperation, their courtesy, and their helpful disposition.

Nearly all potential conflicts were resolved through friendly negotiation, accommodation and common sense compromise, and in the end, practical solutions were found to problems of substance and to problems of procedure without recourse to costly and time-consuming formal procedures.

But above all, I want to thank the people of Elliot Lake at the institutional and at the personal level for their patience, for their kindness, and for their affability. All of us working on the Commission were made to feel welcome in your beautiful city when we were far away from our homes and our families.

I personally have received many dinner and social invitations, and I have refused all of them, not because of ingratitude or incivility, but in order to maintain the appearance of neutrality and the absence of bias, and as a result, I ate quite a few lonely microwave TV dinners much to my chagrin, and I think I probably ended up adding an extra notch to my belt as a result of that unfortunate circumstance.

This community has lived through some very dark days on and since the 23rd day of June of 2012. The scars left behind from the deaths of Doloris Perizzolo and Lucie Aylwin will likely never be erased from your collective memory and from the memory obviously of friends and family.

But still, one cannot but admire the spirit of this community as you rebuild and replace what you have lost, and hopefully your experience through the instrumentality of our Report will lead to a safer Ontario for the benefit of all of its citizens.

I can't promise yet a specific date for the publishing of our Report. There is still too much material to be analyzed and digested. Many of our lawyers are in Ottawa at the moment engaged in that very task, and we hope to be able to announce a firm date in the latter part of the month of November.

With the assistance of our editor, Mr. Bindman in Ottawa, we are close to having the front and back covers designed, and I have a picture of it here, and we have only got a little step left to go and that is to fill – to put in the filler between the front and the back pages.

Of this, however, you can be certain of, as I have said in French, that report will be made public here and nowhere else when my team and I return one final time here to Elliot Lake to release it.

We look very much forward to that day.

I thank you all very much.



## Appendix K – Commission Rules and Procedural Orders

### K.1 Revised Rules of Standing and Funding

#### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner

[info@elliottinquiry.ca](mailto:info@elliottinquiry.ca)



#### LA COMMISSION D'ENQUETE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

[info@elliottinquiry.ca](mailto:info@elliottinquiry.ca)

### REVISED RULES OF STANDING AND FUNDING

#### General

1. These Rules of Standing and Funding apply to the Elliot Lake Commission of Inquiry (the “Commission” or “Inquiry”), established pursuant to Order in Council 1097/2012 (the “Terms of Reference”).
2. Subject to the *Public Inquiries Act, 2009*, S.O. 2009, c. 33, Sched. 6 (the “Act”) and the Terms of Reference, these Rules are issued by The Honourable Paul Bélanger (the “Commissioner”), in his discretion to facilitate the efficient disposition of the issues of standing and funding.
3. The Commissioner may amend these Rules or dispense with compliance of these Rules as he deems necessary to ensure the Inquiry is thorough, fair and timely.
4. All interested persons and their counsel shall be deemed to undertake to adhere to these Rules, and may raise any issue of non-compliance with the Commissioner.
5. The Commissioner may deal with a breach of these Rules as he deems appropriate.
6. In these Rules,
  - a. “persons” refers to individuals, groups, governments, agencies, institutions or any other entity;
  - b. “electronic format” refers to pdf format.

#### Standing

7. Commission Counsel, who will assist the Commissioner to ensure the orderly conduct of the Inquiry, have standing throughout the Inquiry. Commission Counsel have the primary responsibility of representing the public interest throughout the Inquiry, including the responsibility of ensuring that all matters that bear upon the public interest are brought to the Commissioner’s attention.

8. Persons may seek standing at the Inquiry by way of motion in writing with supporting materials, to be filed, in electronic format if possible, with the Commission on or before October 17, 2012, or at the discretion of the Commission on any other date.
9. Motions in writing for standing must include the following information:
  - a. The person's name, address, telephone number, and fax number and e-mail address, if available;
  - b. The name(s) of the lawyer(s), if any, representing the person, together with the lawyer(s)'s address, telephone number, fax number and email address;
  - c. The nature of the person's interest in the subject matter of the inquiry, why he/she wishes standing, and how he/she proposes to contribute to the Inquiry, having specific regard to the Terms of Reference and the Commissioner's remarks delivered on August 15, 2012;
  - d. Whether the person is seeking full standing or standing on one or more specific issues as outlined in the Terms of Reference; and
  - e. Whether the person wishes to make oral submissions in support of the motion for standing.
10. A person who wishes to make oral submissions in support of the motion for standing may be given an opportunity to appear in person, or by counsel, and make oral submissions at a hearing at a date and time to be determined. The Commissioner will allocate time for oral submissions for each person who is permitted to make oral submissions.
11. Standing will be granted in the discretion of the Commissioner, in accordance with section 15 of the Act, the Terms of Reference and the desirability of a fair and expeditious proceeding. The Commissioner will consider, among other things, the following factors:
  - a. whether a person has a substantial and direct interest in the subject matter of the Inquiry;
  - b. whether a person is likely to be notified of a possible finding of misconduct under section 17 of the Act;
  - c. whether a person's participation would further the conduct of the Inquiry;
  - d. whether a person's participation would contribute to the openness and fairness of the Inquiry.

12. The Commissioner may determine the manner and scope of the participation of persons granted standing, as well as their rights and responsibilities.
13. The Commissioner may direct that a number of applicants share in a single grant of standing.
14. All materials filed in support of a person's motion in writing for standing will be available to the public on the Commission's website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca).
15. Those granted standing will be designated as Participants before the Inquiry.
16. Subject to the Rules of Procedure yet to be published, the Participants in the Inquiry may have, at the Commissioner's discretion, among other things,:
  - a. Access to documents collected by the Commission subject to the Rules of Procedure;
  - b. Advance notice of documents which are proposed to be introduced into evidence;
  - c. Advance provision of will say statements of anticipated witnesses;
  - d. A seat at counsel table;
  - e. The opportunity to suggest witnesses to be called by Commission Counsel, failing which an opportunity to apply to the Commissioner to lead the evidence of a particular witness;
  - f. The right to cross-examine witnesses on matters relevant to the basis upon which standing was granted;
  - g. The right to make closing submissions.
17. The Commissioner may decide, in his discretion, that one or more applicants for standing will have more limited rights of participation than others. He may also decide that two or more applicants for standing will be required to participate as a group, and be required to exercise their rights of participation jointly.
18. Any updated information with respect to standing may be made available on the Commission's website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca).

#### **Funding**

19. Further to paragraph 11 of the Terms of Reference, the Commissioner may make recommendations to the Attorney General regarding funding for a party to the



extent of the party's interest, where in the Commissioner's view, the party would not otherwise be able to participate in the inquiry without such funding.

20. Persons may seek funding by way of motion in writing with supporting materials to be filed, in electronic format if possible, with the Commission on or before October 17, 2012, or at the discretion of the Commissioner on any other date. Persons will be expected to seek funding at the same time as they seek standing, and motion materials prepared in support of funding may be combined with motion materials prepared in support of standing.
21. Motions in writing for funding must include the following information:
  - a. The person's name, address, telephone number, and fax number and e-mail address, if available;
  - b. The name(s) of the lawyer(s), if any, representing the person, together with the lawyer(s)'s address, telephone number, fax number and email address;
  - c. Evidence that demonstrates that a person does not have adequate financial resources that enables it to represent its interest;
  - d. How it intends to make use of the funds and how it will account for the funds; and
  - e. Whether the person wishes to make oral submissions in support of the motion for funding.
22. A person who wishes to make oral submissions in support of the funding motion may be given an opportunity to appear in person, or by counsel, and make oral submissions in support of the motion for funding at a hearing at a date and time to be determined by the Commission. The Commissioner will allocate time for oral submissions for each person who is permitted to make oral submissions.
23. Funding will be recommended at the Commissioner's discretion in accordance with paragraph 11 of the Terms of Reference. The Commission will also consider, among other things, the following factors in making his funding recommendations:
  - a. the nature of the applicant's interest and/or proposed involvement in the Inquiry;
  - b. whether the applicant has an established record of concerns for and a demonstrated commitment to the interest it seeks to represent;

- c. whether the applicant has special experience or expertise with respect to the Commission's mandate; and
  - d. whether the applicant has attempted to form a group with others of similar interests.
- 24. Where the Commissioner's funding recommendation is accepted, funding shall be in accordance with applicable Management Board of Cabinet directives and guidelines respecting rates or remuneration and reimbursement and the assessment of accounts.
- 25. All materials filed in support of a party's motion in writing for funding will be available to the public on the Commission's website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca).
- 26. Any updated information with respect to funding may be made available on the Commission's website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca).

## K.2 Revised Rules of Procedure

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner

info@elliottinquiry.ca



### LA COMMISSION D'ENQUETE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

info@elliottinquiry.ca

## RULES OF PROCEDURE

**(REVISED DECEMBER 20, 2012)**

### General

1. These Rules of Procedure (“Rules”) apply to the Elliot Lake Commission of Inquiry (the “Commission” or “Inquiry”), established pursuant to the *Public Inquiries Act*, 2009, S.O. 2009 c.33, sched. 6 (the “Act”) and Order in Council 1097/2012 (the “Terms of Reference”).
2. Subject to the *Act*, the conduct of, and procedure to be followed at, the Inquiry is under the control and discretion of the Honourable Paul R. Bélanger (the “Commissioner”).
3. The Commissioner may amend these Rules or dispense with compliance with these Rules as he deems necessary to ensure that the Inquiry is thorough, fair and timely.
4. All participants, witnesses and their counsel shall be deemed to undertake to adhere to these Rules and may raise any issue of non-compliance with the Commissioner.
5. The Commissioner may deal with any non-compliance with these Rules as he deems appropriate, including by revoking the standing of a participant or imposing restrictions on a participant.
6. In these Rules,
  - a. “person” refers to individuals, groups, governments, agencies, institutions or any other entity;
  - b. “participant” refers to a person who has been granted standing to participate in the Commission pursuant to the Revised Rules of Standing and Funding; and
  - c. “document” is intended to have a broad meaning, and includes the following forms: written, electronic, audiotape, videotape, digital reproductions, photographs, maps, graphs, microfiche and any data and information recorded or stored by means of any device.



### Investigation

7. The Inquiry will commence with an investigation by Commission Counsel. The goal of the investigation, in part, will be to identify the core and background facts and to identify witnesses.
8. The investigation will consist primarily of document review, consultation with interested persons, and witness interviews by Commission staff and Commission Counsel.

### Document Production

9. Copies of all relevant documents must be produced to the Commission by any participant or recipient of a summons by the Commission at the earliest opportunity, in a format acceptable to the Commission. Prior to taking part in the Commission, each participant or summons recipient, if a natural person, or the chief executive officer of each participant or summons recipient, if a corporation, must certify in writing that this obligation has been complied with.
10. Production to the Commission by a participant or summons recipient will not constitute a waiver of any claim to privilege, including solicitor-client privilege, which a participant or summons recipient may wish to assert. Participants or summons recipients are, however, requested to identify to Commission Counsel, within a reasonable time period, in accordance with the procedure set out in paragraph 11, any documents over which they intend to assert a claim of privilege.
11. Where a participant or summons recipient objects to the production of any document, or part thereof, on the grounds of privilege, pursuant to subsection 8(3) of the *Act*, the following procedures will apply:
  - a. The participant or summons recipient shall deliver to Commission Counsel a list setting out pertinent details of the document(s), or part thereof, over which claims for privilege are being asserted. This shall include the date, author, recipient and a brief description of the document(s), and may include additional material, such as an affidavit, to support its claims;
  - b. Commission Counsel shall review the list and decide if they will recommend to the Commissioner that he accept the claim for privilege;
  - c. If Commission Counsel are not prepared to recommend to the Commissioner that he accept the claim for privilege, the list and any further material filed by the participant or summons recipient shall be submitted forthwith, together with Commission Counsel's written submissions, to the Commissioner or, at the Commissioner's option, to the Honourable Stephen T. Goudge, Justice of the Ontario Court of Appeal, for determination. If the Commissioner or Justice Goudge is unable to make a determination based on the record before them, they may request a copy of the disputed document(s) for inspection; and

- d. If the claim for privilege is dismissed, the document(s) shall be produced to Commission Counsel forthwith.
12. Originals of relevant documents are to be provided to Commission Counsel only upon their request and where doing so would not interfere with any potential or ongoing investigation or legal proceeding. The participants will otherwise preserve originals of relevant documents until such time as the Commissioner has fulfilled his mandate or has ordered otherwise.
13. Counsel to the participants and witnesses will be provided with documents and information, including statements of anticipated evidence, only upon executing the written undertaking at Appendix "A" that all such documents and information will be used solely for the purposes of the Inquiry.
14. Counsel are entitled to provide those documents or information to their clients only on terms consistent with the undertakings given, and after the clients have entered into the written undertaking at Appendix "B" to the same effect.
- 14.1 Potential witnesses or participants who are unrepresented will also be entitled to receive documents or information relevant to their testimony after having entered into the written undertaking at Appendix "C".
- 14.2 The Commission orders that each person who has entered into a written undertaking in the form set out at Appendix "A", "B" or "C" comply with its terms. Failure to do so will be a breach of an order of the Commission.
15. These undertakings will be of no force or effect if any of the conditions of s. 12(2) or 12(3) of the *Act* are met.
16. The Commission may require that the documents provided, and all copies made, be returned to the Commission if not tendered in evidence.
17. Where a participant or summons recipient objects to the disclosure of a document or information to other participants and/or to the public at the hearing or otherwise on the grounds of confidentiality, and seeks an order pursuant to subsections 10(4) or 14(3) of the *Act*, a copy of the document and/or the information in issue will be produced in an unedited form to the Commission. The participant or summons recipient shall provide, in writing, a submission setting out the order requested and the reasons for it. In determining whether to make the order, the Commissioner will consider, among other things, the duty of procedural fairness to the other participants and his obligation pursuant to section 17 of the *Act*.
- 17A. Rules 10, 11 and 17 apply, with necessary modifications, to persons who have had documents seized by the Ontario Provincial Police or the Ministry of Labour in the course of their respective investigations, and whose documents were then delivered to the

Commission by the Ontario Provincial Police or the Ministry of Labour pursuant to a summons issued by the Commission.

### **Evidence**

#### *(i) General*

18. The Commission may collect and receive information that it considers relevant and appropriate, whether or not the information would be admissible in a court of law and in whatever form the information takes, and may accept the information as evidence at the Inquiry. However, pursuant to section 8(3) of the *Act*, nothing is admissible in evidence at the Inquiry that would be inadmissible in a court by reason of any privilege under the law of evidence.
19. In accordance with sections 4 and 5 of the Terms of Reference and section 9 of the *Act*, the Commission may prepare Overview Reports which may contain core or background facts.
20. Commission Counsel will provide a reasonable opportunity to the participants, in advance of the filing of Overview Reports as evidence, to comment on the accuracy of the Overview Reports, and the Commission may modify the Overview Reports in response. Participants may also, pursuant to Rule 31, propose witnesses to be called to support, challenge, comment upon or supplement the Overview Reports in ways that are likely to significantly contribute to an understanding of the issues relevant to this Inquiry.
21. The Overview Reports may be used to assist in identifying systemic issues relevant to the Inquiry, to make findings of fact and to enable recommendations to be made, but the Overview Reports will not be used in a manner precluded by section 3 of the Terms of Reference.
22. The Commission will rely, wherever possible, on the Overview Reports and may consider such reports instead of calling witnesses.
23. Commission Counsel may call witnesses or experts who may, among other things, support, comment upon or supplement the Overview Reports.
24. Evidence may be received at the Inquiry from one or more panels of expert witnesses.
25. The Commissioner may modify these Rules as may be appropriate for the disclosure of documents and the questioning of panelists by the participants.

#### *(ii) Oral Hearings and Witnesses*

26. The Commissioner will conduct hearings as set out in these Rules.
27. The Commissioner will set the dates, hours and place of the hearings.



28. The Commission anticipates that the hearings will take place in two parts, one dealing with events prior to the collapse of the Algo Centre Mall in Elliot Lake on June 23, 2012, and the other dealing with events on and after that date. The Commission further anticipates that each part will include two distinct phases, namely:

1) Part 1 will include

- a) an inquiry into the events prior to the collapse of the Algo Centre Mall, the cause of the collapse, and a review of the relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the structural integrity and safety of the Algo Centre Mall; and
- b) consideration of the policy issues that arise with respect to the issues explored in the first phase;

2) Part 2 will include

- a) an inquiry into the events surrounding the collapse of the Algo Centre Mall and the emergency management and response, and a review of the relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the emergency management and response to the collapse of the Algo Centre Mall; and
- b) consideration of the policy issues that arise with respect to the issues explored in the first phase.

28.1 In due course, the Commission will issue a procedural order establishing the process by which it will consider the policy issues referred to in Rule 28.

29. The Commissioner may make such orders or give such directions as he considers proper to maintain order and to prevent the abuse of the Commission's process.

30. Participants may propose witnesses to be called as part of the Inquiry. Participants will provide to Commission Counsel the names and addresses of all witnesses they believe ought to be heard and will provide Commission Counsel, where applicable, with copies of all relevant documents, including statements of anticipated evidence, at the earliest opportunity.

31. Commission Counsel will have discretion to refuse to call or present evidence proposed by a participant. A participant may, however, apply to the Commissioner for leave to call a witness whom the participant believes has information relevant to the Commission's mandate. If the Commissioner is satisfied that the information of the witness is required, Commission Counsel will call the witness subject to Rule 38.

32. Anyone interviewed by or on behalf of Commission Counsel is entitled, but not required, to have counsel present for the interview to represent his or her interests.
33. Witnesses who are not represented by counsel for participants are entitled to have their own counsel present while they testify. Counsel for the witness will be permitted to make appropriate objections during the testimony of that witness.
34. Witnesses may be called more than once.
35. Witnesses will give their evidence at a hearing under oath or affirmation.

#### **Rules of Examination**

36. In the ordinary course, Commission Counsel will call and question witnesses who testify at the Inquiry. Except as otherwise directed by the Commissioner, Commission Counsel are entitled to adduce evidence by way of both leading and non-leading questions.
37. Participants will have an opportunity to cross-examine the witness, to the extent of their interest, as determined by the Commissioner. The Commissioner will determine the order of cross-examinations.
38. Counsel for a participant may apply to the Commissioner to examine a particular witness in chief. If counsel is granted the right to do so, examination will be confined to the normal rules governing the examination of one's own witness.
39. The Commissioner may direct any counsel whose client shares a commonality of interest with the witness only to adduce evidence through non-leading questions.
40. Counsel for a witness, regardless of whether he or she is also representing a participant, will examine after the other participants have concluded their cross-examinations. If he or she has adduced the evidence of the witness in chief, he or she will have a right to re-examine the witness. If, however, that counsel for the witness intends to adduce evidence in chief not adduced by Commission Counsel, he or she will examine the witness immediately following Commission Counsel and will then have a right to re-examine the witness following the cross-examinations by the other participants.
41. Commission Counsel has the right to re-examine any witness at the conclusion of his or her evidence.
42. The Commissioner may set time allocations for the conduct of examinations and cross-examinations.

**Use of Documents at Hearing**

43. In advance of the testimony of a witness, Commission Counsel will endeavour to provide the participants with reasonable notice of the subject matter of the anticipated evidence in chief and a list of the documents associated with that evidence.
44. In cases where counsel other than Commission Counsel is intending to lead the evidence in chief of a witness, they will provide the participants with reasonable notice of the subject matter and a list of documents associated with that evidence.
45. Neither participants nor Commission Counsel will be entitled to cross-examine a witness on any “will-say statement” (anticipated evidence statement or witness interview summary) that may be provided, except with leave of the Commissioner.
46. Participants who intend to cross-examine a witness will provide reasonable notice of any documents to which they intend to refer during their cross-examination, other than those documents for which notice has previously been provided, pursuant to Rules 43 or 44.
47. For the purpose of these Rules, the Commissioner will have discretion to determine what constitutes “reasonable notice” or “at the earliest opportunity” in all of the circumstances.
48. The Commissioner may grant Commission Counsel or counsel for a participant or witness leave to introduce a document to a witness at any point during the hearing upon such terms as are just and fair.

Dated October 9, 2012. Revised November 8, 2012. Revised December 20, 2012.



## K.3 Notice to Participants re undertakings

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

### Notice to participants and counsel

1. Subsection 12(1) of the *Public Inquiries Act, 2009* provides:

**12. (1)** Subject to this section, all participants and their lawyers or agents are deemed to undertake not to use information obtained from another participant or collected or received by the commission for any purpose other than that of the public inquiry in which it was obtained.

**(2)** Subsection (1) does not prohibit the following:

1. A use to which the person who disclosed the information consents.
2. The use, for any purpose, of information that is disclosed to the public.
3. The use, for any purpose, of information that is provided or referred to during a hearing.
4. The use, for any purpose, of information obtained from information referred to in paragraph 2 or 3.
5. The use of information to impeach the testimony of a person in another proceeding or for a prosecution for perjury in respect of that testimony.

2. Articles 13, 14, 14.1, and 14.2 of the Commission's *Rules of Procedure* (revised Dec. 20, 2012) provide:

**13.** Counsel to the participants and witnesses will be provided with documents and information, including statements of anticipated evidence, only upon executing the written undertaking at Appendix "A" that all such documents and information will be used solely for the purposes of the Inquiry.

**14.** Counsel are entitled to provide those documents or information to their clients only on terms consistent with the undertakings given, and after the clients have entered into the written undertaking at Appendix "B" to the same effect.

**14.1** Potential witnesses or participants who are unrepresented will also be entitled to receive documents or information relevant to their testimony after having entered into the written undertaking at Appendix "C".

**14.2** The Commission orders that each person who has entered into a written undertaking in the form set out at Appendix "A", "B" or "C" comply with its terms. Failure to do so will be a breach of an order of the Commission.

3. The Undertaking found at Appendix "A" provides the following:

1400 Blair Place, 6<sup>th</sup> Floor  
Ottawa, Ontario K1J 9B8

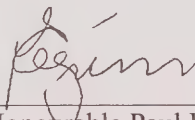
info@elliottlakeinquiry.ca

1400, Place Blair, 6<sup>e</sup> étage  
Ottawa (Ontario) K1J 9B8

I, \_\_\_\_\_, undertake to the Elliot Lake Commission of Inquiry that any and all documents which are produced to me in connection with the Commission's proceedings will not be used by me for any purpose other than those proceedings. I further undertake that I will not disclose those documents to anyone for whom I do not act or who has not been retained as an expert for the purposes of the Inquiry.

4. I will expect strict and meticulous compliance with the confidentiality undertakings. Documents have been produced to the Commission in response to its summonses in the expectation of such compliance.
5. Counsel are not allowed to share documents provided to them by the Commission that do not fall within the exceptions set out in s. 12(2) of the *Public Inquiries Act, 2009* with anyone other than a Participant who has been granted standing, a witness or an expert retained for the purposes of the Inquiry. In this regard, I wish to emphasize that counsel are **not** allowed to share documents with insurers, as no insurer has been granted standing before the Commission.

ISSUED at Ottawa, Ontario, this 18<sup>th</sup> day of January, 2013.



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The Honourable Paul R. Bélanger  
Commissioner

## K.4 Procedural Order 7

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Procedural Order No. 7

Counsel for Robert Wood, a participant in this Inquiry, has advised that he intends to bring an application before the Commissioner seeking an order that the Commissioner's report be redacted prior to being publicly released to delete any reference to Mr. Wood or his actions relating to the Algo Centre Mall, and that the redacted portions be not released publicly until completion of the process relating to charges brought against Mr. Wood under the *Criminal Code*.

**IT IS HEREBY ORDERED THAT** the following process will apply to this Application:

1. Mr. Wood's application materials, including:
    - a. a Notice of Application which shall
      - i. state the precise order or other relief sought;
      - ii. state the grounds to be argued, including a reference to any statutory provision to be relied upon; and
      - iii. list the documentary evidence to be used at the hearing of the Application;
    - b. evidence by way of
      - i. reference to particular evidence (by transcript date, page, and line number, or by exhibit number) already entered as evidence in the Inquiry; and/or
      - ii. affidavit from one or more witnesses; and
    - c. a factum consisting of a concise argument stating the facts and law relied on by the party
- shall be served on the Commission, each of the Participants in Part 1 of the Inquiry, and Crown counsel with carriage of the criminal prosecution against Mr. Wood, by 5:00 p.m. Friday, May 16, 2014.
2. The Commission will provide notice of this Application, and copies of the materials, to media organizations.
  3. A Participant, Crown counsel, or media organization wishing to make submissions at the hearing of this Application shall:
    - a. provide written notice to the Commission and all Participants by 5:00 p.m. Friday, May 23, 2014; and

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Ottawa, Ontario K1G 6C4

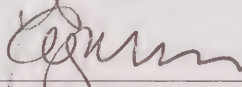
info@elliottlakeinquiry.ca

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Ottawa (Ontario) K1G 6C4



- b. serve by 5:00 p.m. Friday, May 30, 2014 on the Commission and all persons who have provided notice in accordance with the preceding subparagraph its application materials, including
  - i. evidence by way of
    - 1. reference to particular evidence (by transcript date, page, and line number, or by exhibit number) already entered as evidence in the Inquiry, and/or
    - 2. affidavit from one or more witnesses; and
  - ii. a factum consisting of a concise argument stating the facts and law relied on by the party.
- 4. Service of materials relating to this Application may be made by e-mailing a copy to the office of the lawyer for the person being served and, in the case of the Commission of Inquiry, e-mailing a copy to [info@elliottlakeinquiry.ca](mailto:info@elliottlakeinquiry.ca). An affidavit of service is to be provided to the Commission on the next business day.
- 5. All materials relating to this Application shall be posted on the Commission's website.
- 6. The Application shall be heard at 10:00 a.m. on Friday, June 20, 2014 in Courtroom number 9 at the Courthouse, 161 Elgin Street, Ottawa, Ontario.

ISSUED at Ottawa, Ontario, this 29<sup>th</sup> day of April, 2014.



The Honourable Paul Bélanger  
Commissioner

## K.5 Procedural Order 8

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

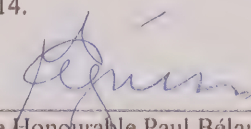
## Procedural Order No. 8

The Commission may, from time to time, provide an opportunity to individual participants to make further submissions on particular issues. Any such submissions will be posted on the Commission's website and notice of the submission provided to all Participants in the Part of the Inquiry to which the submissions relate.

### IT IS HEREBY ORDERED THAT:

1. All Participants in the Part of the Inquiry to which such submissions ("the original submissions") relate are entitled to provide a written response to the submissions ("responding submissions").
2. Responding submissions shall be provided to the Commission by email sent to [info@elliottlakeinquiry.ca](mailto:info@elliottlakeinquiry.ca) by 5:00 pm on the 7<sup>th</sup> day after the posting of the original submissions.
3. In calculating the time within which responding submissions shall be provided, the day that the original submissions are posted shall not be included but the day responding submissions are received shall be included; weekends and holidays are included in the seven days but if the seventh day falls on a weekend or holiday responding submissions may be provided on the next business day.
4. Any responding submissions will be posted on the Commission's website. No Participant shall have an opportunity to file a submission in response to responding submissions.

ISSUED at Ottawa, Ontario, this 1st day of May 2014.

  
The Honourable Paul R. Bélanger  
Commissioner

## K.6 Procedural Order 9

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Procedural Order No. 9

On May 8, 2014, the Commission received the anonymous letter at Appendix “A” along with the report at Appendix “B” entitled “Deterioration of Parking Structures” (the “Report”). The Report, dated July 1988, had not been produced to the Inquiry during its investigation and appears to have been prepared by an Advisory Committee struck by the Ministry of Housing. Members of the Advisory Committee included individuals from the Ministry of Housing, Trow Group, Halsall Robt & Associates Ltd. and Construction Control Ltd. The Commission is considering the impact of the Report on its mandate and investigation and wishes to provide an opportunity to the Participants, including the Ontario Government, to make submissions in this regard.

### IT IS HEREBY ORDERED THAT:

1. The Ontario Government shall serve on the Commission and each Participants in Part I of the Inquiry, by 5:00 p.m. Friday, May 23, 2014, submissions, and related documents, in relation to the following questions:
  - a. Confirm the authenticity of the Report.
  - b. Describe what steps, if any, were taken by the Ontario Government upon receipt of the Report, including whether it established a comprehensive repair and restoration program (see p. ii of Report). If no steps were taken (or no program established), please explain why;
  - c. Did the Ontario Government conduct any additional study following the Report? If so, describe.
  - d. Did the Ontario Government adopt any of the recommendation set out in the Report? If so, describe the measures taken and how they were implemented?
  - e. Provide any documentation in relation to items b, c and d set out above.
2. A Participant to Part I of the Inquiry wishing to make submissions with respect to the Report and/or in response to the Government’s submissions shall serve such submissions by 5:00 p.m. Friday, June 6, 2014 on the Commission and the Participants Part I.
3. Service of materials relating to this Procedural Order may be made by e-mailing a copy to the Commission of Inquiry and Commission Counsel at



[info@elliottlakeinquiry.ca](mailto:info@elliottlakeinquiry.ca) and [counsel@elliottlakeinquiry.ca](mailto:counsel@elliottlakeinquiry.ca) and to counsel for the Participants Part I at [participants@elliottlakeinquiry.ca](mailto:participants@elliottlakeinquiry.ca).

4. All materials relating to this Application shall be posted on the Commission's website.

ISSUED at Ottawa, Ontario, this 12<sup>th</sup> day of May, 2014.

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The Honourable Paul Bélanger  
Commissioner

## K.7 Procedural Order 12

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Procedural Order No. 12

On April 25, 2014, Robert Wood, a Participant in this Inquiry, wrote Commission Counsel advising that he intended to bring an application before me seeking an order that my report be redacted prior to being publicly released to delete any reference to Mr. Wood and that the redacted portions not be released publicly until the completion of the process relating to charges brought against Mr. Wood under the *Criminal Code*.

On April 29, 2014, I issued Procedural Order No. 7 setting out the process to be followed by Mr. Wood, the items Mr. Wood's application should contain and a schedule for this application and the submissions, if any, of Participants or media organizations. On the same day, Commission Counsel advised counsel for Mr. Wood that the Commission expected that the materials to be filed with respect to the application would contain evidence to support all of the arguments he intended to make, and more specifically would include:

- (a) A copy of the information in the Ontario Court of Justice setting out the charges against Mr. Wood, including all endorsements made by the Court at each appearance;
- (b) An indication of whether Mr. Wood has yet been asked to make an election as to the court which will try him and whether that trial will be by a judge sitting alone or a judge sitting with a jury and what election, if any, he has made;
- (c) If he has not yet made an election, an indication of whether he has yet decided how he will elect and what that decision is.

On May 13, 2014, Mr. Wood sought an extension of the initial deadline for serving his Application to May 20, 2014, which I granted in Procedural Order No. 10.

On May 20, 2014, Mr. Wood filed an Application Record with the Commission consisting of a Notice of Application, an Affidavit by Mr. Wood's co-counsel and a Factum. In his Application, Mr. Wood sought a remedy different from the one he had advised Commission Counsel of on April 25. In his Application, Mr. Wood outlines a two-step process whereby he seeks as a first step:

- 1) an order that Mr. Wood and his legal representative Robert MacRae be permitted to review the final draft of the Elliot Lake Commission of Inquiry report in advance of the report being made public, and further;

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Ottawa, Ontario K1G 6C4

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- 2) an Order that such review be restricted to passages that reference Robert Wood and further;
- 3) that such review will be for the sole purpose of determining whether in the opinion of Mr. Wood and his legal representative Robert MacRae there are passages and or references in the Report of the Commission that would impact on the right of Mr. Wood to obtain a fair trial pursuant to section 11(d) of the *Canadian Charter of Rights and Freedoms*.

Mr. Wood then proceeds to outline the remedies he would seek should I grant the above-noted relief, namely a period of time for the review of the draft final report, along with a new timeline for the hearing and determination of the second part of his Application, if he deems it necessary, and a further review after Mr. Wood's preliminary inquiry is completed of any preliminary order I may make with respect to redaction of my report.

I have several concerns about Mr. Wood's Application, which lead me to modify the process to deal with his Application and issue a new timetable. They are:

First, the Order in Council creating my mandate provides that I shall deliver a final report containing my findings, opinions, and conclusions to the Attorney General no later than October 31, 2014. I have been working diligently towards this deadline, which I intend to meet.

Second, Mr. Wood's filed Application is materially different from the one he advised Commission Counsel he would make. Indeed, no notice was given of Mr. Wood's intention to bring a two-step application. This attempt to bifurcate (or potentially trifurcate) the Application creates an unacceptable and unnecessary delay. In my view, Mr. Wood would suffer no prejudice if he is required to argue all of his application on June 20 as I outline below.

Third, I am concerned about the lack of responsiveness of Mr. Wood's material to Commission Counsel's request. Mr. Wood did not provide any of the information and documents requested by Commission Counsel, all of which are essential to understanding the circumstances surrounding Mr. Wood's request.

Fourth, it appears that the information provided by Mr. Wood is inaccurate in that he claims that "there is a requirement for the Ontario Court of Justice to conduct a Preliminary Hearing with respect to these criminal charges" (Wood Factum, para. 18). There is only a requirement for a preliminary hearing to be held if Mr. Wood elects to be tried before a Superior Court judge sitting alone or with a jury and if he or the prosecutor requests a preliminary hearing (subsections 536(2) and (4) of the *Criminal Code*). Mr. Wood could choose to be tried before the Ontario Court of Justice, in which case he is not entitled to a preliminary hearing (subsection 536(2) of the *Criminal Code*). In addition, Mr. Wood suggests that the election of the mode of trial takes place after and not before the holding of a preliminary hearing (Wood Notice of Application, paras. 29 and 33). In fact, subsections 536(2) and (4) of the *Criminal Code* make an election, or failure to elect, as to mode of trial a condition precedent to the holding of a preliminary hearing.



Fifth, Mr. Wood's Application raises, in my view, an important jurisdictional issue. Paragraphs 12 and 15 of the Order in Council creating the Commission provide that:

12. The Commission shall deliver a final report containing its findings, conclusions and recommendations to the Attorney General no later than October 31, 2014. [...]

15. The Attorney General shall table the report with the Legislature and make the report available to the public.

It would appear, at first blush, that I am bound by these terms, which dictate that I produce the report to the Attorney General who, in turn, will make it public. It may be argued that I do not have the authority to publicly disclose the report and that Mr. Wood's request should be directed to the Attorney General. As matters stand, the report remains entirely confidential. I would welcome submissions on this jurisdictional issue.

Sixth, Mr. Wood argues that he is seeking a draft of the final report in order to assess whether any redaction is needed because (1) he does not know what will be contained in my report, and (2) he does not want to make broader requests for redaction than he needs to for the protection of his right to a fair trial. I am perplexed by Mr. Wood's position. He has, in his Application, disclosed to the public that he was the recipient of a Section 17 notice pursuant to the *Public Inquiries Act, 2009*, which provides him with notice of the possible findings of misconduct and a summary of the evidence supporting such possible findings. Section 17 is the statutory embodiment of the Commission's duty to provide procedural fairness to those persons who may be affected by its activities. Mr. Wood can safely assume that the findings I make in my report about him and his actions will not go beyond the potential findings outlined in the Section 17 notice. Consequently, I will require from Mr. Wood additional submissions as to why the Section 17 notice he received is insufficient to provide him with adequate notice of what will be contained in the report to allow him to proceed with his redaction request.

**IN LIGHT OF THE ABOVE, IT IS HEREBY ORDERED THAT:**

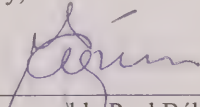
1. Mr. Wood shall serve on the Commission, each of the Participants in Part 1 of the Inquiry, and Crown counsel with carriage of the criminal prosecution against Mr. Wood any Additional Submissions which he may have, including, but not limited to:
  - a. A copy of the information in the Ontario Court of Justice setting out the charges against Mr. Wood, including all endorsements made by the Court at each appearance;
  - b. An indication of whether Mr. Wood has yet made an election as to the court which will try him and whether he will be tried by a judge sitting alone or with a jury and, if so, what the election was;
  - c. If he has not yet made an election, an indication of whether he has yet decided how he will elect and what that decision is;

- d. Submissions with respect to my jurisdiction to entertain his request;
- e. Submissions with respect to the necessity to obtain a final draft of the report given that he has obtained a Section 17 notice pursuant to the Public Inquiries Act, 2009;
- f. If I decline Mr. Wood's request for a copy of the final draft report, his full submissions in the alternative with respect to any further orders he may require.

by 5:00 p.m. Friday, May 30, 2014.

- 2. The Commission will provide notice of Mr. Wood's Additional Submissions, and copies of the materials, to media organizations.
- 3. A Participant, Crown counsel, or media organization wishing to make submissions at the hearing of this Application shall:
  - a. provide written notice to the Commission and all Participants by 5:00 p.m. Friday, June 6, 2014; and
  - b. serve by 5:00 p.m. Friday, June 13, 2014 on the Commission and all persons who have provided notice in accordance with the preceding subparagraph its application materials, including
    - i. evidence by way of
      - 1. reference to particular evidence (by transcript date, page, and line number, or by exhibit number) already entered as evidence in the Inquiry, and/or
      - 2. affidavit(s) from one or more witnesses; and
    - ii. a factum consisting of a concise argument stating the facts and law relied on by the party.
- 4. Service of materials relating to this Application may be made by e-mailing a copy to the office of the lawyer for the person being served and, in the case of the Commission of Inquiry, e-mailing a copy to [counsel@elliottlakeinquiry.ca](mailto:counsel@elliottlakeinquiry.ca) and [info@elliottlakeinquiry.ca](mailto:info@elliottlakeinquiry.ca). An affidavit of service is to be provided to the Commission on the next business day.
- 5. All materials relating to this Application shall be posted on the Commission's website.
- 6. The Application shall be heard at 10:00 a.m. on Friday, June 20, 2014 in Courtroom number 9 at the Courthouse, 161 Elgin Street, Ottawa, Ontario.

ISSUED at Ottawa, Ontario, this 22<sup>nd</sup> day of May, 2014.

  
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 The Honourable Paul Bélanger  
 Commissioner

# Appendix L – List of overview reports

Rule 19 of the Commission's *Rules of Procedure* provide that the Commission may prepare Overview Reports which may contain core or background facts. The *Rules* also provide that the Overview Reports could be used to assist in identifying systemic issues relevant to the Inquiry. Rule 22 provide that the Commission would rely, whenever possible, on the Overview Reports instead of calling witnesses.

A number of these reports were filed as exhibits at the outset of the hearings for Parts 1 and 2. Participants were offered the opportunity to comment on the reports prior to them being entered as exhibits. The comments were received and considered.

These reports allowed for the admission in evidence of relevant and generally uncontroverted but pertinent information without the necessity of calling witnesses. These reports were very useful and practical time savers. It would have been impossible to have a witness speak to every one of these documents and still meet the time constraints imposed on us by the order in council.

The following overview reports were filed:

- (a) Designing and Building a Large Construction Project and appendix;<sup>1</sup>
- (b) History of the City of Elliot Lake;<sup>2</sup>
- (c) Ownership history;<sup>3</sup>
- (d) Tenancies and appendix;<sup>4</sup>
- (e) State of Disrepair and appendix;<sup>5</sup>
- (f) Elliot Lake Public Library and appendix;<sup>6</sup>
- (g) Leaks at Zellers and appendix;<sup>7</sup>
- (h) Leakage at the Algo Centre Mall Scotiabank and appendix;<sup>8</sup>
- (i) Emergency Management Overview;<sup>9</sup> and
- (j) Incident Management System.<sup>10</sup>

## Notes

<sup>1</sup> Exhibit 6

<sup>2</sup> Exhibit 7

<sup>3</sup> Exhibit 8

<sup>4</sup> Exhibit 9

<sup>5</sup> Exhibit 10

<sup>6</sup> Exhibit 11

<sup>7</sup> Exhibit 12

<sup>8</sup> Exhibit 13

<sup>9</sup> Exhibit 5847

<sup>10</sup> Exhibit 8006



# Appendix M – Rulings

## M.1 Ruling on Standing and Funding

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Ruling on Standing and Funding

### The Inquiry Process

I have been appointed by Order in Council 1097/2012 to conduct an inquiry to:

- a. Inquire into and report on events surrounding the collapse of the Algo Centre Mall in Elliot Lake, Ontario, the deaths of Lucie Aylwin and Doloris Perizzolo and the injuries to other individuals in attendance at the mall and the emergency management and response by responsible bodies and individuals subsequent to the collapse;
- b. Review relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the structural integrity and safety of the Algo Centre Mall in Elliot Lake, Ontario;
- c. Review relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the emergency management and response to the collapse of the Algo Centre Mall Elliot Lake, Ontario.

The Commission has published its draft *Rules of Procedure* on its website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca). Section 28 of those *Rules* states that I anticipate conducting the hearings in two parts: one dealing with events prior to the collapse of the Algo Centre Mall in Elliot Lake on June 23, 2012, and the other dealing with events on and after that date. Section 4 of the Order in Council further states:

4. Where the Commissioner considers it essential and at his discretion, he may engage in any activity appropriate to fulfilling his duties, including:

[...]

- b. Conducting inter-jurisdictional research to identify practices and successes in other jurisdictions that are relevant to the Ontario experience;

At a later time, the Commission will, in consultation with parties granted standing, determine the best way to identify practices and successes in other jurisdictions that are relevant to the Ontario experience.

Public hearings will be held at the White Mountain Academy of the Arts in Elliot Lake, when witnesses will give evidence on oath or affirmation and will be examined and cross-examined by Commission Counsel and counsel for parties granted standing. Parties with standing will make

closing submissions when the witnesses have all been heard. I will later announce the commencement date of those hearings.

Parties granted standing by this order may make submissions relating to the *Rules of Procedure* as presently promulgated and, if appropriate, those *Rules* may be changed or amended to reflect those submissions. Any such submissions should be provided to the Commission within 30 days of this Ruling.

### Standing and Funding

Pursuant to its mandate, on September 26, 2012 the Commission published *Rules of Standing and Funding*<sup>1</sup> and invited those interested in seeking standing and funding to apply in writing by October 17, 2012. In September 2012, the Inquiry also issued a Call for Applications for Standing and Funding in several major and legal newspapers.

Section 15 of the *Public Inquiries Act, 2009* provides:

#### PARTICIPATION AT A PUBLIC INQUIRY

##### Determination of participation

15. (1) Subject to the order establishing the commission, a commission shall determine,

- (a) whether a person can participate in the public inquiry;
- (b) the manner and scope of the participation of different participants or different classes of participants;
- (c) the rights and responsibilities, if any, of different participants or different classes of participants; and
- (d) any limits or conditions on the participation of different participants or different classes of participants.

##### Considerations

(2) Before making a decision under subsection (1), the commission shall consider,

- (a) whether a person has a substantial and direct interest in the subject matter of the public inquiry;
- (b) whether a person is likely to be notified of a possible finding of misconduct under section 17;
- (c) whether a person's participation would further the conduct of the public inquiry; and
- (d) whether a person's participation would contribute to the openness and fairness of the public inquiry.

##### Representation

(3) A person who is permitted to participate in a public inquiry,

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<sup>1</sup> On the same day, the Commission issued *Revised Rules of Standing and Funding*.

- (a) may participate on their own behalf;
- (b) may be represented by a lawyer; or
- (c) may, with the leave of the commission, be represented by an agent.

Section 11 of the *Revised Rules of Standing and Funding* provides that standing will be granted at the discretion of the Commissioner, in accordance with Section 15 of the *Act* above, the Commission's Terms of Reference as outlined in the Order in Council and the desirability of a fair and expeditious proceeding.

As per Rule 16 of the *Revised Rules of Standing and Funding*, participants in the Inquiry with standing may have:

1. Access to documents collected by the Commission subject to the *Rules of Procedure*;
2. Advance notice of documents which are proposed to be introduced into evidence;
3. Advance provision of statements of anticipated evidence;
4. A seat at counsel table;
5. The opportunity to suggest witnesses to be called by Commission Counsel, and if those witnesses are not called, the opportunity to apply to me to lead the evidence of a particular witness;
6. The right to cross-examine witnesses on matters relevant to the basis upon which standing was granted;
7. The opportunity to make closing submissions; and
8. The opportunity to apply for funding pursuant to the *Revised Rules on Standing and Funding*.

To avoid repetition and unnecessary delay, as discussed below, I have urged certain applicants to be grouped together, where the applicants have similar interests or perspectives, and where there is no apparent conflict of interest. I have grouped applicants together where I am satisfied that the relevant interest or perspective will be fully and fairly represented by a single grant of standing to the parties as a group.

Commission Counsel will assist me throughout the Inquiry. They do not represent any particular interest or point of view. Their role is not adversarial or partisan. Their principal responsibility is to ensure that all matters bearing upon the public interest are brought to my attention. They will have full standing throughout.

On the issue of funding, I note that I do not have the power to order funding to applicants. The Order in Council provides that I may make recommendations to the Attorney General regarding funding to participants where in my view the participants would not otherwise be able to participate in the Inquiry without such funding. Any funding provided will have to be in accordance with applicable Management Board of Cabinet Directives and Guidelines ("*Guidelines for Reimbursement of Legal Fees and Disbursements*"). They may be found on our website.



In addition, Rule 23 of the *Revised Rules of Standing and Funding* provides that the Commissioner will also consider, among other things, the following factors in making his funding recommendations:

- a. the nature of the applicant's interest and/or proposed involvement in the Inquiry;
- b. whether the applicant has an established record of concerns for and a demonstrated commitment to the interest it seeks to represent;
- c. whether the applicant has special experience or expertise with respect to the Commission's mandate; and
- d. whether the applicant has attempted to form a group with others of similar interests.

On October 15, 2012, I also issued Procedural Order No. 1 in which I drew the attention of the persons applying for funding to Rule 21 of the *Revised Rules of Standing and Funding*, and more specifically Rule 21(c), which describes the evidence that must be filed in support of such a request. Individuals or organizations who had already filed their Motion for Funding were advised that they may choose to file further material by October 17, 2012.

### **Applications for Standing and Funding**

Eighteen groups or individuals sought standing and/or funding by the deadline. The Commission set Friday October 26, 2012 at the Hampton Inn Hotel in Elliot Lake as the date for hearing motions for standing and funding. However, a number of persons and organizations/associations were advised beforehand that they did not need to attend that hearing.<sup>2</sup> I heard submissions from six applicants.

The chart at Appendix "A" identifies the applicants, their counsel, the part of the hearings for which they desire standing and/or funding and the nature of funding they are seeking.

### **Decisions on Standing and Funding**

#### **1) Standing**

With the factors set out above in mind, I now turn to the eighteen requests for standing that the Commission has received. The full list of persons granted standing can be found at Appendix "B" to this ruling.

#### **Réjean Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan**

<sup>2</sup> See Procedural Order No. 2 issued October 19, 2012. Following the issuance of this Order, Non-Profit Retirement Residences of Elliot Lake and 1425164 Ontario Ltd. withdrew their request for funding and were therefore advised that their presence was not required. Further, Stuart Brindley advised the Commission that he was unable to attend and was therefore relying on his written submissions.

These Applicants are the families of the two Elliot Lake residents who died in the Mall collapse, Lucie Aylwin and Doloris Perizzolo. Réjean and Rachelle Aylwin are the father and mother of Lucie Aylwin and Stéphane is her brother. Teresa Perizzolo and Cindy Lee Allan are the daughters of Doloris Perizzolo.

Clearly, as the families of the victims of this tragedy, they have a direct and substantial interest in the work of this Inquiry. **Full standing is granted.**

**Eastwood Mall Inc., Robert Nazarian and Levon Nazarian**

Eastwood Mall Inc. owned the Algo Centre Mall from 2005 to the present date, including on the date of the collapse. The Notice of Application and accompanying submissions assert that Robert Nazarian is a director, President, owner and operator of Eastwood Mall Inc.; Levon Nazarian, his son, worked for Eastwood Mall Inc. as an independent contractor and administrator; and Levon Nazarian oversaw the administration of Eastwood Mall Inc.'s business transactions, including assisting with the leases and retaining contractors and engineers.

This corporation and these individuals are directly connected to the ownership and management of the Mall at the time of the collapse. They are the object of a number of investigations. They submit that they anticipate receiving notices pursuant to Section 17 of the *Public Inquiries Act, 2009*. They clearly have a significant, substantial and direct interest. They have requested standing in relation to **Part 1** of the Inquiry and standing is **granted** as requested.

**Non-Profit Retirement Residences of Elliot Lake Inc. and NorDev 1425164 Ontario Ltd.**

Non-Profit Retirement Residences of Elliot Lake Inc. was the sole shareholder of 1309900 Ontario Ltd, later amalgamated into 1425164 Ontario Ltd., which owned the Algo Centre Mall from 1999 to 2005.

As a previous owner of the Mall, this entity has a substantial and direct interest in the subject matter of the Inquiry and its participation would further the conduct of the Inquiry. Standing in relation to **Part 1** of the Inquiry is **granted**.

**Robert Wood and Greg Saunders**

Messrs. Wood and Saunders were employed by and shareholders of the engineering firm M.R. Wright and Associates that conducted inspections for, and reported to, the owners of the Algo Centre Mall prior to the collapse. M.R. Wright and Associates is a defendant in individual and class action lawsuits. They have requested standing in relation to **Part 1** of the Inquiry. Since they may have conflicting or opposing positions to advance at the Inquiry, individual standing is **granted** to each of them as requested.

**Martinette Venter, Shoppers Drug Mart Associate #667**

As the owner and operator of the lottery ticket kiosk whose employee, Lucie Aylwin, was killed by the collapse, this Applicant has a substantial and direct interest in the subject matter of the

Inquiry and her participation would further the conduct of the Inquiry. Standing in relation to **Part 1** of the Inquiry is **granted**.

#### **Government of Ontario**

The Government, particularly the Ministry of Community Safety and Correctional Services, the Ministry of Labour and the Ontario Provincial Police, has a clear and important interest in the issues raised by the Order in Council and meets the criteria for full standing. **Full standing** in all aspects of the work of the Commission is **granted**.

#### **The Corporation of the City of Elliot Lake**

The City of Elliot Lake has a clear and important interest in the issues raised by the Order in Council and meets the criteria for full standing. **Full standing** in all aspects of the work of the Commission is **granted**.

#### **Elliot Lake Mall Action Committee (“ELMAC”)**

The Elliot Lake Mall Action Committee is a community group that represents a large number of owners/operators, employers and employees of stores and businesses in the Algo Centre Mall as well as persons injured by the collapse. It is seeking full standing.

Prior to the October 26, 2012 hearing, I requested that ELMAC, Peter Unfried and the Seniors' Action Group of Elliot Lake (“SAGE”) discuss the possibility of being grouped together under one grant of standing. On October 26, 2012, ELMAC advised that Mr. Unfried had agreed to be represented by ELMAC. ELMAC advised that it was still in discussion with SAGE about possible cooperation and joint representation. I provided ELMAC until noon on November 2, 2012 to advise me of the outcome of these discussions with SAGE. On November 2, 2012, I was advised by ELMAC that while SAGE continued to seek full standing, it had come to an agreement with counsel for ELMAC to be represented by ELMAC's counsel group.

Being the only broad-based community group seeking standing before this Commission, it is evident that ELMAC has a clear and important interest in the issues raised by the Order in Council. It meets the criteria for **full standing**, which is **granted**. I address below the request for standing of SAGE.

#### **Association of Professional Engineers of Ontario (“PEO”)**

The PEO is the licensing and regulatory body for professional engineering in the Province of Ontario. It has launched two investigations related to the collapse of the Algo Centre Mall. The PEO has issued guidelines in connection with the practice of professional engineering, including guidelines relating to professional engineers providing services in construction and building. The PEO clearly has an important interest and expertise in the issues raised by the Order in Council and is **granted standing** in relation to **Part 1** as requested in its notice of motion.

#### **Ontario Association of Fire Chiefs**



This association represents the chief fire officers of the 462 municipal fire departments in Ontario, which employ 30,526 firefighters, career, part-time and volunteer. The Association's mission is leading innovation and excellence in public and life safety. This Association's expertise will clearly be of value to the Inquiry in relation to emergency management and response. Standing in relation to **Part 2** of the Inquiry is **granted**.

**Ontario Building Officials Association ("OBOA")**

The OBOA, which has approximately 2,000 active members, is a self-governing, not-for-profit corporation which supports Ontario building officials by delivering training and certification. Since 1974, it has been selected annually by the Ontario government to deliver training courses related to the *Ontario Building Code* and is permitted by statute to grant the designation of Certified Building Code Official to those who have satisfied its established qualifications. It also publishes quarterly the *Journal*, its professional magazine for its members. OBOA clearly has an important interest and expertise in the issues raised by the Order in Council and is **granted standing** in relation to **Part 1** as requested in its notice of motion.

**Elliot Lake Professional Fire Fighters Association, IAFF Local 1351, Toronto Professional Fire Fighters Association, IAFF Local 3888, Ontario Professional Fire Fighters Association (OPFFA) and the International Association of Fire Fighters (IAFF)**

The Elliot Lake firefighters initially responded to the collapse of the Algo Centre Mall and members of the Toronto local responded as members of the Heavy Urban Search and Rescue ("HUSAR") team. The OPFFA and the IAFF are the provincial and international associations to which the Elliot Lake and Toronto locals are affiliated.

The members of these associations, conveniently grouped together, have a substantial and direct interest in the subject matter of the Inquiry and their participation would further the conduct of the Inquiry. They will, together as one group, be **granted** standing in relation to **Part 2** of the Inquiry.

**Ontario Society of Professional Engineers (the "Society")**

The Society is a not-for-profit corporation concerned with promoting the professional and economic interests of professional engineers in Ontario. It has approximately 6,000 members who are professional engineers and another 3,000 members who are in other engineering categories. The Society was created in 2000 to separate the regulatory (PEO) and non-regulatory affairs of the engineering profession in Ontario. The Society clearly has an important interest and expertise in the issues raised by the Order in Council and is **granted standing** in relation to **Part 1**.

**Stuart J. Brindley**

Mr. Brindley is the founder and president of S.J. Brindley Consulting Inc., a consulting company specializing in emergency management, with experience across North America addressing issues related to critical infrastructure protection. He is a registered Professional Engineer with more than 29 years in the electricity sector and has led the development of the electricity sector's critical infrastructure protection program across North America.

Mr. Brindley was unable to attend the hearing and advised the Commission that he relied on his written submissions. However, he is not an area resident, was not a witness to any of the events in question and has no financial or proprietary interest that relates to the subject matter of the Inquiry. I find that he does not meet the criteria contained in Section 11 of the *Revised Rules on Standing and Funding* and standing is consequently **not granted**. Commission Counsel, however, may wish to contact him to determine if he can provide any informal assistance to their work.

#### **Peter D. Unfried**

Mr. Unfried was the owner of Thomsen's The Jewellery Doctor, which was located in the Mall. At the hearing on October 26, 2012, Mr. Unfried withdrew his motion and agreed that his interests were similar to those of ELMAC and could be advanced by that organization. There is therefore no longer any motion for standing before me by Mr. Unfried.

#### **Victim Services of Algoma**

Victim Services of Algoma is a volunteer-based not-for-profit Transfer Agency which responds to calls for local police services and emergency services to assist victims of crime and tragic circumstances. It is funded by the Ministry of Attorney General through the Victims Justice Fund.

At the hearing, Commission Counsel gave assurances to Victim Services of Algoma that the interests of the organization would be addressed by the Commission at the hearings. The organization was advised that the Executive Director (and other members of the organization if requested) would be interviewed at length by Commission Counsel and that she would be called as a witness. The organization appeared fully satisfied by those assurances. Standing is **not granted** to this Applicant.

#### **Seniors' Action Group of Elliot Lake ("SAGE")**

This is a recently-formed organization whose mission is to "defend, advance and communicate" the common interests of its members who are seniors and retirees of Elliot Lake. Its members attend Council and committee meetings and host a Web site. It produces reports and correspondence to both its members and citizens at large, as well as politicians and government officials at all levels.

I was advised on November 2, 2012 that, while SAGE continued to seek full standing, it had come to an agreement with counsel for ELMAC to be represented by ELMAC's counsel group. Consequently, given that SAGE's interests can and will be represented by ELMAC, standing is **granted** on the condition that SAGE be represented by the same counsel as ELMAC. Should a conflict arise between SAGE and ELMAC, SAGE will be free to make a new application for standing.

## 2) Funding

The following are my recommendations on funding, which are also summarized at Appendix “C”.

### Elliot Lake Mall Action Committee (“ELMAC”)

This community group represents a large number of individuals who have been financially impacted (or in some cases devastated) by the collapse of the Mall. Many have lost their businesses or employment. In support of its request for funding, ELMAC has filed the Affidavit of Jean Pomerleau, one of the three members of its steering committee, in which he describes the financial means of the group.

The ELMAC’s submissions in support of its request for funding can be summarized as follows:

1. ELMAC is a volunteer not-for-profit association and does not have financial resources to participate in the Inquiry;
2. ELMAC has no assets or source of revenue and does not charge a fee to its members to join; and
3. ELMAC’s membership is largely composed of retired individuals on a fixed income, business owners who have seen their occupation and sole means of income destroyed in the Mall’s collapse and former Mall workers who lost their employment and who may face an uncertain financial future.

As previously noted, ELMAC has agreed to represent the interests of SAGE and Peter D. Unfried. I am satisfied that without funding, they could not properly participate in the work of this Inquiry. I recommend to the Attorney General that funding for one senior and one junior counsel be provided in accordance with the *Guidelines for Reimbursement of Legal Fees and Disbursements*, on the understanding that the senior counsel position will alternate between Messrs. R. Douglas Elliot, Jeff Broadbent and Roland Aubé.

### Greg Saunders

As part of his Application, Mr. Saunders sought funding. However, on November 6, 2012, counsel for Mr. Saunders advised the Commission that funding would be provided to Mr. Saunders by his insurer and he therefore withdrew his request for funding.

### The Corporation of the City of Elliot Lake

The application filed by the Corporation of the City of Elliot Lake (“City of Elliot Lake” or “City”) included a request for standing but no request for funding. Commission Counsel was advised by Counsel for the City, John Walker, that the City’s insurance company would be funding the City’s appearance before the Commission.

However, on October 23, 2012, Commission Counsel was advised by the City’s counsel that the insurer had decided not to fund his expenses to appear before the Commission and that the



Application for Standing would now be handled by Wishart Law Firm LLP. On October 24, 2012, Paul Cassan of Wishart Law Firm LLP confirmed that he was acting on behalf of the City and that on October 26, 2012 he would be seeking from the Commission an extension of time to file a request for funding.

At the hearing on October 26, 2012, I granted the City of Elliot Lake one further week, until noon on November 2, 2012, to provide material in support of an application for funding, in view of the change in counsel and the issue relating to the municipality's insurance coverage.

On November 2, 2012, the City of Elliot Lake filed a Motion Record comprised of a Notice of Motion for an order recommending funding as well as two affidavits. The first affidavit was sworn by Robert deBortoli, Chief Administrative Officer for the City ("deBortoli Affidavit") and the second affidavit was sworn by Linda Hurdle, Assistant to Mr. Cassan ("Hurdle Affidavit"). In his Affidavit, Mr. deBortoli outlines the history of the City of Elliot Lake as well as its current financial situation. He also includes as exhibits, among other things, the following supporting documents:

1. The City's 2011 audited financial statements;
2. Assessment documentation and tax bills for the Algo Centre Mall;
3. The City's 2012 Budget Summary;
4. The City's Emergency Response Costs following the Algo Mall collapse;
5. The City's 2013 Budget;
6. The City's Consolidated Statement of Accumulated Surplus for the year 2011; and
7. Documentation relating to the City's liability coverage.

The Hurdle Affidavit provides a copy of the KPMG study the City undertook to find out whether there were any further expenses it could cut to mitigate its financial position. Ms. Hurdle also advised being informed by Mr. deBortoli that all identifiable cost cutting measures available to the City have been completed.

The City's submissions in support of its request for funding can be summarized as follows:

1. In 2010, the City cut the municipal tax rate from 2.99% to 2.00% which resulted in the diminution of the City reserves; the City no longer has a Working Capital Reserve fund or a Tax Rate Stabilization Fund;
2. The loss of the Mall has resulted in 200 lost jobs City-wide;
3. The loss of the Mall represents a loss of over \$180,000 in tax revenue for the City, which represents two percent of the municipal tax base;
4. As a result of the collapse, the City has incurred expenses for the emergency response of over \$130,000;
5. As a result of the loss of facilities, the City has been required to fund part of the renovation of the White Mountain Academy at a cost of \$240,772;
6. The City is involved in the acquisition and site preparation for the "Pearson Plaza" which will replace the Algo Centre Mall; the cost of this site preparation is \$3.5 million, of which the City expects to fund at least \$700,000;
7. The City has exceeded its budget for legal fees for 2012;

8. A tax increase of 5.1% is projected for the 2013 budget. An additional 3.91% tax increase would be required to cover the legal fees for the preparation and attendance at the Inquiry; and
9. The City does not have any insurance coverage for the legal representation before the Inquiry.

The City of Elliot Lake has evidently been directly impacted fiscally by the collapse of the Algo Centre Mall. The Municipality is a relatively small one and does not have sufficient reserves to fund legal representation, particularly for the entire term of the Commission hearings. There are no insurance proceeds to cover this representation. I recommend to the Attorney General that funding for one senior counsel and one junior counsel be provided in accordance with the *Guidelines for Reimbursement of Legal Fees and Disbursements*. Counsel for the City has advised that different lawyers from Wishart Law Firm LLP will replace counsel on occasion and that the City is not seeking funding for more than one senior counsel to be present at the Inquiry at any one point.

#### **Ontario Building Officials Association (“OBOA”)**

On October 11, 2012, along with its Motion for Standing, the Commission received a Motion for Funding from the OBOA. The Motion Record consisted of a Notice of Motion along with an Affidavit from Ronald M. Kolbe, Chief Administrative Officer of the OBOA. In his Affidavit, Mr. Kolbe advises that the OBOA’s revenue sources are sufficient to allow it to efficiently undertake its day-to-day operations and fulfill its corporate objects, train and educate its members and provide services to its membership. He further advises that the OBOA does not have adequate financial resources to cover the costs to retain legal counsel to allow it to participate at the Inquiry. He states that to fund the OBOA’s participation at the Inquiry constitutes an extraordinary and unforeseen expense beyond the Association’s financial resources.

On October 15, 2012, Commission Counsel wrote to Counsel for the OBOA advising that it would be of assistance if he could provide further evidence to establish that, if funding is not provided, the OBOA would not be able to participate in the Inquiry. Commission Counsel further advised:

We are particularly interested in the financial statements of your client for this fiscal year and the preceding year, setting out its assets and liabilities, and revenue and expenses, both anticipated and actual year to date, together with the amount and purpose of any reserves. If you wish to apply for an order of confidentiality in respect of this information, the procedure is set out in the Commission’s Rules of Procedure.

On October 17, 2012, the OBOA filed a Supplemental Motion Record including a Supplemental Affidavit of Ronald M. Kolbe. In this Supplemental Affidavit, Mr. Kolbe provided copies of the 2011, 2010 and 2009 audited OBOA annual financial statements disclosing the financial standing of the Association. He further explained that the use of OBOA’s reserve funds were restricted to the purposes for which they were established with a clear corporate objective.

In considering the OBOA's request for funding, I have considered the decision on Standing and Funding rendered by Commissioner O'Connor in the Walkerton Inquiry. Commissioner O'Connor stated that the expression "the party would not otherwise be able to participate in the Inquiry without such funding" does not require a demonstration of impecuniosity before funding could or should be recommended. In particular, in relation to organizations, Commissioner O'Connor was satisfied that where financial reserves for such organizations were dedicated to financing their core objects, purposes or activities it was appropriate to conclude that, without funding, such organizations would not otherwise be able to participate in the Inquiry. Among others, in the Walkerton Inquiry, Commissioner O'Connor recommended funding to the Association of Municipalities of Ontario and the Professional Engineers and Architects of the Ontario Public Service. The same principle was adopted by Commissioner Glaude in the Cornwall Inquiry where he recommended funding to the Diocese of Alexandria-Cornwall. In my view, the same principles apply in the case of the OBOA.

I therefore recommend to the Attorney General that funding for one senior counsel be provided in accordance with the *Guidelines for Reimbursement of Legal Fees and Disbursements*.

**Eastwood Mall Inc., Robert Nazarian and Levon Nazarian**

Eastwood Mall Inc. and Robert Nazarian first applied for standing and funding on or about October 5, 2012 when they were represented by Antoine-René Fabris. The application consisted of three and a half pages comprising a Notice of Application, but no affidavit or evidence.

On October 15, 2012, following the issuance of Procedural Order No. 1, Commission Counsel wrote to Mr. Fabris advising him that it would be of assistance to the Commission if he could provide evidence to establish that, if funding is not provided, Robert Nazarian and Eastwood Mall Inc. would not be able to participate in the Inquiry. Commission Counsel further advised:

The following questions address particular issues in which the Commission is interested, but are not intended to limit your client's obligation to provide evidence on this issue.

We are particularly interested in financial statements from each of your clients, showing their assets and liabilities and, for Eastwood Mall Inc., projected (and actual year to date) revenue and expenses for this fiscal year and the prior fiscal year. We would expect that these financial statements would provide sufficient detail to allow the Commissioner to determine the issue he is required to determine, and would include any notes to financial statements prepared by the accounting firm responsible for their preparation. For Mr. Nazarian, we would appreciate, in addition to the financial statement showing his assets and liabilities, evidence to show his income, actual and expected, for 2011 and 2012, and a copy of his income tax return for 2011.

We would also be interested in details of the insurance available to either of your clients with respect to the events of June 23, 2012, and particulars and supporting documentation with respect to the last sentence of paragraph 6 of your application.



At paragraph 6 of their application, Eastwood Mall Inc. and Robert Nazarian stated that insurance proceeds were being held in trust pending the result of any liability claims. No additional evidence was received from Mr. Fabris on behalf of his client.

On October 17, 2012, the Commission received a new application for standing and funding from Eastwood Mall Inc., Robert Nazarian and Levon Nazarian through their counsel Pradeep Chand and Peter Thorning (Brauti Thorning Zibarras). The new application was submitted in addition to, and jointly with, the application brought by Mr. Fabris. The application consisted of a notice of application and submissions on standing and funding, but was not supplemented by affidavits or evidentiary material of any sort. Subsequently, on the same day, Commission Counsel wrote to Messrs. Fabris and Chand acknowledging receipt of the application, to be considered jointly with Mr. Fabris' application. Commission Counsel noted that the Commission had not yet received any additional evidence requested in the letter to Mr. Fabris of October 15, 2012.

Later on October 17, 2012, the Commission received an affidavit from Oliver Fonseca, law clerk at Brauti Thorning Zibarras in support of the application ("Fonseca Affidavit"). The Fonseca Affidavit contained bare and unsupported claims consisting entirely of hearsay statements.

On October 22, 2012, Commission Counsel wrote to Messrs. Fabris and Chand asking whether their clients had approached their insurance company to find out whether it would cover their legal representation before the Commission. On the same day, Commission Counsel spoke with Mr. Chand who advised that he was putting together an affidavit with more financial information, which he would be submitting together with an application that the financial information be the subject of a confidentiality order. No material was received by the Commission on October 22, 2012.

On October 24, 2012, Mr. Chand advised that he expected to deliver his materials shortly. On the same day, Commission Counsel advised Mr. Chand that the Commissioner expected him to attend on October 26, 2012 if his clients intended on proceeding with their request for funding. Commission Counsel further advised that if Mr. Chand filed an application for a confidentiality order, he should expect to be asked by the Commission to address, in the public session, whether the persons granted standing as participants and the media ought to be given notice and an opportunity to be heard on the question of whether the confidentiality order ought to be issued. Commission Counsel referred Mr. Chand to *Dagenais v. Canadian Broadcasting Corp.*<sup>3</sup>, *Episcopal Corporation of the Diocese of Alexandria-Cornwall v. Cornwall Public Inquiry*.<sup>4</sup>, *Vancouver Sun (Re)*<sup>5</sup>, *Toronto Star Newspapers Ltd. v. Ontario*<sup>6</sup> and *Named Person v. Vancouver Sun*<sup>7</sup>.

On October 24, 2012, at 5:39 p.m., the Commission received a Book of Documents containing the following financial records related to Robert Nazarian, Levon Nazarian and Eastwood Mall Inc., along with submissions in support of a confidentiality order:

<sup>3</sup> [1994] 3 S.C.R. 835.

<sup>4</sup> 2007 ONCA 20.

<sup>5</sup> 2004 SCC 43, [2004] 2 S.C.R. 332.

<sup>6</sup> 2005 SCC 41, [2005] 2 S.C.R. 188.

<sup>7</sup> 2007 SCC 43, [2007] 3 S.C.R. 253.

1. CRA Notice of Assessment for Tax Years 2007, 2008 and 2011 for Robert Nazarian;
2. CRA Income Tax and Benefit Return for Tax Year 2011 for Robert Nazarian;
3. Bank account statements for Robert Nazarian for various periods between July 1 and October 18, 2012;
4. Profit and Loss/Balance Sheets for Eastwood Mall Inc. for January 1 to June 23, 2012;
5. Financial records and correspondence from Eastwood Mall Inc.'s accountants for the periods January 1, 2010 to December 31, 2010 and January 1, 2011 to December 31, 2011;
6. CRA Income Tax Return for Eastwood Mall Inc. for Tax Year 2011; and
7. CRA Income Tax and Benefit Return for Tax Year 2011 for Levon Nazarian.

At the hearing on October 26, 2012, I was informed that Antoine-René Fabris no longer represented these Applicants. I was also advised by Mr. Chand that paragraph 40 of the Applicants' Application on Funding, which stated that "Insurance proceeds are being held in trust pending the result of any liability claims" was submitted in error. Mr. Chand submitted that the Applicants had not received any insurance proceeds and that there are no monies held in trust in any lawyer's account. Mr. Chand further confirmed that the Applicants' insurance policy does not cover legal representation at the Inquiry and that the insurance company would not provide any *ex gratia* payments for legal representation and/or attendance at the Inquiry. I specifically advised Mr. Chand that this is the kind of information I would like to get proof about and that I wished to receive this information as part of his new material.

At the hearing, I informed counsel that in my opinion the material provided in support of their application was deficient, in that it did not constitute "evidence" as required by Section 21(c) of the *Rules on Standing and Funding*. None of the material provided was in original form. None of the documents formed part of sworn affidavits attesting to the accuracy of their content. No original certification was attached to any of the documents. In addition, their application was submitted only on October 24, well beyond the October 17 deadline specified by the *Rules*.

I nevertheless granted the Applicants a further week to submit new material, until noon on November 2, 2012. At the request of counsel, I also agreed to impose a temporary sealing order on the material already submitted until counsel have been given the opportunity to request and justify a confidentiality order. Counsel were further advised to be prepared to discuss the need to notify the media and other parties of any confidentiality request as well as to provide the media and other parties with an opportunity to make submissions on any such request. I will shortly be issuing a procedural order outlining the procedure to be followed with respect to the confidentiality order request.

On November 2, 2012, the three Applicants filed an Application Record, containing all materials originally submitted to the Commission plus the following additional documents:

1. Supplementary Submissions on Funding;
2. Affidavit of Fabio Brussolo ("Brussolo Affidavit");

3. Affidavit of Sam Hurmizi (“Hurmizi Affidavit”);
4. Affidavit of Robert Nazarian (“Nazarian Affidavit”);
5. Letters from Michael Title, dated October 26, 2012;
6. Order to Prohibit Use and Occupancy, dated October 24, 2011;
7. Contract for the Demolition of the Algo Centre Mall;
8. Supplementary Submissions on behalf of the Diocese of Alexandria-Cornwall at the Cornwall Inquiry;
9. CRA Income Tax and Benefit Return for Tax Years 2008, 2009 and 2010 for Robert Nazarian;
10. Profit and Loss/Balance Sheets for Yorkdale Group Inc. as of 30 September 2012; and
11. Profit and Loss/Balance Sheets for Yorkdale Centres Inc. as of 30 September 2012.

I wish to address first the legal issue raised by the Applicants in their supplementary submissions. The Applicants urge me to recognize that the expression in the Order in Council “the party would not otherwise be able to participate in the Inquiry without such funding” does not require a demonstration of impecuniosity before funding is recommended. As I have explained in my ruling on funding for the OBOA, I agree that proof of impecuniosity is not a requirement. Indeed, financial reserves are not an impediment to a recommendation of funding. However, applicants seeking funding must be forthright and provide the Commission with a clear picture of their net worth, including their revenues, expenses, assets and liabilities.

A careful review of the documents provided by Eastwood Mall Inc., Robert Nazarian and Levon Nazarian leads me to conclude that they have not provided sufficient evidence to justify why they would not otherwise be able to participate in the Inquiry without such funding. In my view, their evidence is wholly deficient. In light of the temporary sealing order I granted on October 26, 2012, I will refrain from referring in this ruling to specific information contained in the documents provided.

The Applicants’ submissions in support of their request for funding can be summarized as follows:

1. Eastwood Mall Inc.’s sole source of income ceased on the date of the collapse of the Algo Centre Mall;
2. Eastwood Mall Inc. was a significant source of both Robert and Levon Nazarian’s income;
3. The Applicants have no sufficient source of income to support the funding for the Inquiry;
4. Eastwood Mall Inc. and Robert Nazarian are the subject of civil lawsuits; and
5. Robert Nazarian is the president and director of two other corporations, Yorkdale Group Inc. and Yorkdale Centre Inc.

The two individual Applicants claim that it is “very clear that they do not have sufficient finances to fund this Inquiry.” I cannot agree.



The three additional affidavits filed unfortunately do not shed much light on the financial situation of the Applicants. The Brussolo Affidavit confirms that certain documents are genuine copies of what was filed by the Applicants and attests that the three Applicants have lost their most significant source of income. The Hurmizi Affidavit simply confirms that certain documents are genuine copies of what was filed by the Applicants. In his affidavit, Robert Nazarian attests that his *primary* source of income was Eastwood Mall Inc. This implies other sources, but they are not described. A statement to the same effect is made on behalf of Levon Nazarian in the application. It is doubly deficient, in that it is not a sworn statement and is similarly silent about other sources. 2011 tax returns by both individuals may be some evidence of income in that year but say nothing about their current income. More importantly (apart from ownership of Eastwood Mall Inc.), neither Nazarian gives the Commission any information about their personal assets and liabilities, their net worth, their global holdings or property interests. Without that information, it is impossible to arrive at the most rudimentary estimate of their current financial situation.

A further illustration of the incomplete nature of the materials provided is the fact that several entries record the transfer of various large sums into Robert Nazarian's bank account without any explanation about their source.

With regard to Eastwood Mall Inc., the averments contained in the Applicants' submissions and the material provided point to an important interrelationship between Eastwood Mall Inc., Yorkdale Group Inc., Yorkdale Centre Inc. and Robert Nazarian. That relationship, however, is entirely unexplained, beyond statements about Robert Nazarian's position as president and director of the corporate entities (and owner and operator in Eastwood Mall Inc.'s case). The documents provided are completely silent about their corporate structure and share ownership. For example, it is unclear what kind of services or product is provided by Yorkdale Group Inc. and Yorkdale Centre Inc. and who their shareholders are. And yet, the financial statements of Yorkdale Group Inc., Yorkdale Centre Inc. and Eastwood Mall Inc. seem to show large transfers of funds between them.

The unaudited<sup>8</sup> statements provided raise more questions than they answer.

Further, despite the specific request I made at the hearing regarding insurance coverage issues of the Algo Centre Mall, in particular the claim that the Applicants had received no insurance proceeds on account of the collapse, no evidence was provided by the Applicants relating to the nature and extent of coverage.

In view of the nebulous quality of the information provided to me, I am unable to make meaningful distinctions between Robert Nazarian and the corporate entities he is clearly connected to. There are tantalizing indications that these entities operate as a group under Mr. Nazarian's control, but I cannot come to that conclusion with any degree of confidence in view of the paucity of the materials provided.

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<sup>8</sup> The statements provided are at best the subject of a review engagement. In fact, it appears that for the 2010 statements of Eastwood Mall Inc., they are neither audited nor the subject of a review engagement.

Consequently, any absence of evidence relating to Robert Nazarian's wealth or net worth inevitably tends to percolate through to these companies and taints any attempt at a meaningful evaluation of the true financial position of any of the three Applicants.

In his affidavit, Robert Nazarian appears to be referring to the three Applicants requesting funding as a group, related to each other by common interest and joint enterprise.

Even if one of the three Applicants may appear to meet the test for funding, in light of the fact that the Applicants are applying as a group and are clearly financially related (along with Yorkdale Group Inc. and Yorkdale Centre Inc.), I cannot simply recommend funding to one of the Applicants while ignoring the deficiencies in evidence of the other two Applicants.

In conclusion, absent a transparent, full and complete explanation of the connections I have referred to above, and absent properly verified financial statements, I am not able at this time to recommend funding to the Applicants Eastwood Mall Inc., Robert Nazarian and Levon Nazarian.

#### **Recommendation regarding Expenses for Counsel**

It is essential that this Inquiry hold its hearings in Elliot Lake, where this tragic mall collapse took place. However, that will mean added expense, especially for counsel who must travel great distances to get to Elliot Lake. I therefore recommend that the Attorney General consider additional funding for accommodation and travel for counsel whose practice is not in Elliot Lake. Arrangements for rental housing as opposed to hotel accommodations may be more practical and economical in this respect.

### **3) Summary**

I have granted standing to four participants for the full inquiry, eight participants for Part 1 and two participants for Part 2. The full list of persons granted standing can be found at Appendix "B" to this ruling. I have recommended funding for three participants. The list of persons for whom I have recommended funding can be found at Appendix "C".

At all times, I expect parties with similar interests to cooperate with one another and with Commission Counsel to avoid repetition and delay. I will not hesitate to intervene to ensure these limits are respected and this Inquiry is conducted in a fair but expeditious manner.

I thank all of the individuals and groups who have taken the time to file applications and I look forward to working with all those granted standing in this important work.

ISSUED at Ottawa, Ontario, this 8<sup>th</sup> day of November, 2012.

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The Honourable Paul R. Bélanger  
Commissioner

## Appendix "A"

## Summary of Applications for Standing and/or Funding

Applicant	Counsel	Part (1: Events prior to the collapse; 2: Events on or after 23 June 2012)	Request Standing?	Request Funding?	Nature of funding request
Elliot Lake Mall Action Committee ("ELMAC")	Douglas Elliot of Roy Elliot O'Connor LLP and Roland Aubé Jeff Broadbent of Feifel Broadbent Gualazzi LLP	1 & 2	Yes	Yes	one senior counsel, one junior counsel from Roy Elliot O'Connor LLP with periodic assistance from Jeff Broadbent or Roland Aubé as Senior Counsel substituting for Elliot
Réjan Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan	Roger Oatley and Shenthuran Subramaniam of Oatley, Vigmond LLP	1 & 2	Yes	No	
NorDev (1429164 Ontario Ltd.) and Non-Profit Retirement Residences	Douglas Kearns of Kearns Law Office	1	Yes	No	
Eastwood Mall Inc., Robert Nazarian and Levon Nazarian	Pradeep Chand and Peter Thorning of Brauti Thorning Zibarras LLP	1	Yes	Yes	three experienced counsel and one junior counsel; travel and accommodations while in Elliot Lake; disbursements, such as photocopies, faxes, retaining experts etc.
Greg Saunders, P. Eng	Joseph A. Bisceglia of Bisceglia Dumanski Romano	1	Yes	No	



<b>Applicant</b>	<b>Counsel</b>	<b>Part</b> (1: Events prior to the collapse; 2: Events on or after 23 June 2012)	<b>Request Standing?</b>	<b>Request Funding?</b>	<b>Nature of funding request</b>
	& Johnson LLP				
Ontario Building Officials Association (“OBOA”)	Leo F. Longo of Aird & Berlis LLP	1	Yes	Yes	one counsel
Peter D. Unfried	n/a	2	Yes	Yes	one counsel
Robert Wood, B. Sc. Eng.	Michael S. O’Neill of O’Neill DeLorenzi Mendes	1	Yes	No	
Professional Engineers of Ontario	Leah Price	1	Yes	No	
The Corporation of the City of Elliot Lake	Paul Cassan of Wishart Law Firm LLP	1 & 2	Yes	Yes	one senior counsel, two junior counsel, one articling student, one law clerk (only one counsel at any one point), accommodation
Senior’s Action Group of Elliot Lake (“SAGE”)	n/a	1 & 2	Yes	Yes	Costs to obtain documents through the Commission and costs for mailing or courier services.
Victim Services of Algoma	n/a	2	Yes	No	
Elliot Lake Professional Fire Fighters Association (IAFF Local 1351), Toronto Professional Fire Fighters Association (IAFF Local 3888), Ontario Professional Fire Fighters Association	Sean McManus of McManus & Hubler	2	Yes	No	

Applicant	Counsel	Part (1: Events prior to the collapse; 2: Events on or after 23 June 2012)	Request Standing?	Request Funding?	Nature of funding request
(OPFFA) and the International Association of Fire Fighters					
Province of Ontario	Kim Twohig, Darrell Kloeze, Norm Feaver, Heather Mackay and Kirstin Smith	1 & 2	Yes	No	
Shoppers Drug Mart Associate #667, Martinette Venter	Joseph K. Morrison of Mathews, Dinsdale & Clark LLP	1 & 2	Yes	No	
Stuart J. Brindley, P. Eng (S.J. Brindley Consulting Inc.)	n/a	2	Yes	Yes	Cost of travel and accommodation.
Ontario Society of Professional Engineers	Robert England of Miller Thomson LLP	1	Yes	No	
Ontario Association of Fire Chiefs	n/a	2	Yes	No	

## **Appendix “B”**

### **Parties with Standing**

#### **Parties - Full Standing**

Rejean Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan

Government of Ontario

The Corporation of the City of Elliot Lake

Elliot Lake Mall Action Committee

#### **Parties - Part I Standing**

Eastwood Mall Inc., Robert Nazarian and Levon Nazarian

Non-Profit Retirement Residences of Elliot Lake Inc. and NorDev 1425164 Ontario Ltd.

Robert Wood

Greg Saunders

Shoppers Drug Mart Associate #667, Martinette Venter

Association of Professional Engineers of Ontario

Ontario Building Officials Association

Ontario Society of Professional Engineers

#### **Parties - Part II Standing**

Ontario Association of Fire Chiefs

Elliot Lake Professional Fire Fighters Association, IAFF Local 1351, Toronto Professional Fire Fighters Association, IAFF Local 3888, Ontario Professional Fire Fighters Association (OPFFA) and the International Association of Fire Fighters (IAFF)



## Appendix "C"

## Recommendations on Funding

Applicant	Funding recommended	Funding not recommended	Nature of funding
Elliot Lake Mall Action Committee ("ELMAC")	√		one senior counsel, one junior counsel from Roy Elliot O'Connor LLP with periodic assistance from Jeff Broadbent or Roland Aubé as Senior Counsel substituting for R. Douglas Elliot
The Corporation of the City of Elliot Lake	√		one senior counsel, one junior counsel and no more than one senior counsel to be present at the Inquiry at any one point
Ontario Building Officials Association ("OBOA")	√		one senior counsel
Eastwood Mall Inc., Robert Nazarian and Levon Nazarian		√	

## M.2 Ruling on Confidentiality

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUETE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Confidentiality Hearing 17 December 2012

### Ruling on Confidentiality

#### Appearances:

Mr. Peter K. Doody, Commission Counsel

Mr. Mark Wallace, Commission Counsel

Ms. Nadia Effendi, Commission Associate Counsel

Mr. Antoine-René Fabris, counsel for Eastwood Mall Inc., Robert Nazarian and Levon Nazarian (Applicants)<sup>1</sup>

Ms. Louisa Ritacca for the Association of Professional Engineers of Ontario (Applicants)

Mr. Joseph A. Bisceglia for Gregory Saunders

Mr. Rob MacRae for Robert Wood

Mr. Peter M. Jacobsen, counsel for CTV, a division of Bell Media Inc., Canadian Broadcasting Corporation, The Globe and Mail and Shaw Television Limited Partnership (the Media Organizations)

Ms. Alexandra Carr for the Elliot Lake Mall Action Committee ("ELMAC") and Seniors Action Group of Elliot Lake ("SAGE")

Mr. J. Paul Cassan for the City of Elliot Lake

Mr. Shenthuran Subramanian for Rejean Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan<sup>2</sup>

<sup>1</sup> Counsel for Robert Nazarian, Levon Nazarian and Eastwood Mall Inc. was unable to attend in person because of inclement weather but participated via teleconference.

<sup>2</sup> Counsel for Rejean Aylwin, Rachelle Aylwin, Stéphane Aylwin, Teresa Perizzolo and Cindy Lee Allan, Mr. Subramanian, appeared initially at the commencement of proceedings, but withdrew at the noon break.

**Paul R. Bélanger, Commissioner:**

1. Two participants granted standing at this Inquiry seek orders from me relating to the confidentiality of documents produced to the Commission.
2. Robert and Levon Nazarian and Eastwood Mall Inc. seek an order preventing disclosure of all documents produced in support of their application for funding, relying on the power given to a commission by Ss. 10(4) and 14(3) of the Public Inquiries Act, 2009, S.O. 2009 c. 33 (“*PIA*”). On 8 November 2012, I granted these applicants standing in relation to Part 1 of the Inquiry but refused to recommend to the Attorney General that they receive funding. My decision on standing and funding is posted on the Commission’s website at [www.elliottlakeinquiry.ca](http://www.elliottlakeinquiry.ca).
3. The Association of Professional Engineers of Ontario (“PEO”) requests a more limited order under ss. 10(4) of the *PIA*, in relation to documents produced in response to a Commission summons. PEO limits its request to an order that prior to disclosure of any of the documents, certain named and unnamed individuals be given the opportunity to review the documents and make submissions as to the appropriateness of further disclosure “and/or use of such documents.”
4. On December 17, 2012, a hearing was held in Ottawa with notice to all participants with standing as well as to media organizations. Written and oral submissions were received from the participants shown above.
5. At the conclusion of the hearing, I issued a temporary publication ban to be in effect until the rendering of my decision. Documents had been provided to all counsel upon execution of an undertaking that they not disclose them in any way.
6. The City of Elliot Lake, ELMAC and SAGE, the Media organizations and the Victims’ families opposed the applications. Gregory Saunders and Robert Wood supported PEO’s application.
7. In my opening remarks at the confidentiality hearing, I commented that whenever a conflict arises between the expectation of privacy or confidentiality and the open court principle, “jurisprudence has now unquestionably and conclusively established that, as between these two values, the onus of demonstrating primacy in any particular circumstance rests on those who would restrict full and unalloyed publicity and transparency.”
8. In my opinion and for the reasons that follow, the applicants have failed to discharge that onus.
9. The relevant sections of the *PIA*, the Professional Engineers Act, R.S.O. 1990, c P.28 (“*PEA*”) and the Commission’s *Revised Rules of Procedure* are reproduced in Appendix “A” annexed hereto.



**Robert and Levon Nazarian; Eastwood Mall Inc.**

10. Annexed to these participants' amended application for funding were documents which are listed in Appendix "B", and in respect of which a confidentiality order is sought.

11. As part of their application, they submitted a request for a confidentiality order through their original counsel. That request was reiterated by subsequent counsel on 23 November 2012. In the original submissions for a confidentiality order, counsel then acting for the applicants stated:

"...the applicants will rely on the following grounds

- I. There is a high expectation of privacy attached to the records/information
- II. With the exception of this application for funding, the records are not otherwise relevant to the business of the Inquiry
- III. The salutary effects of the order outweigh its deleterious effects.

In the supplementary submissions, counsel stated:

"12. We are not confident that the Commission can ensure that our client's interests of Justice (sic) will be protected, should the Application Record and supporting material be released and/or published.

13. It would be a serious prejudice to the applicants if the materials were to be misused and or used for any other purpose; this would violate the Elliot Lake Commission and more specifically Section 12.1 of the Public Inquiries Act, 2009 (sic).

12. On this issue, the following passages from the recent decision of the Ontario Court of Appeal in *Out-of-Home Marketing Association of Canada v. Toronto (City)*, 2012 ONCA 212 ("Out-Of-Home") are pertinent and instructive:

[51] A request to have exhibits sealed implicates the open court principle, and must be approached with great care. The application judge was required to apply the two-step approach identified in a series of cases from the Supreme Court of Canada involving non-publication orders and/or sealing orders: see *Toronto Star Newspapers Ltd. v. Ontario*, 2005 SCC 41, [2005] 2 S.C.R. 188, at para. 26; *Sierra Club of Canada v. Canada (Minister of Finance)*, 2002 SCC 41, [2002] 2 S.C.R. 522, at paras. 45-46; *R. v. Mentuck*, 2001 SCC 76, [2001] 3 S.C.R. 442, at para. 32. This approach is commonly referred to as the *Dagenais/ Mentuck* test.

[52] In *Mentuck*, Iacobucci J. said, at para. 32:

A publication ban should only be ordered when:

- (a) such an order is necessary in order to prevent a serious risk to the proper administration of justice because reasonably alternative measures will not prevent the risk; and
- (b) the salutary effects of the publication ban outweigh the deleterious effects on the rights and interests of the parties and the public, including the effects on the right to free expression, the right of the accused to a fair and public trial, and the efficacy of the administration of justice.

[53] Under the controlling jurisprudence, before the court can address the degree to which the public's interests may be harmed by the order, the party seeking the order must present evidence that demonstrates that the order is necessary to prevent a serious risk to an important interest expressible in terms of a public interest in confidentiality: see *Sierra Club*, at para. 55. [emphasis added by Commissioner Bélanger]

[54] It has been held that *Mentuck's* requirement that non-publication and sealing orders are potentially justifiable only if "necessary in order to prevent a serious risk to the proper administration of justice", may refer to a serious risk to public interests other than those that fall under the broad rubric of the "proper administration of justice": *Sierra Club of Canada*, at paras. 46-51, 55. However, the interest jeopardized must have a public component. As Doherty observed in *M.E.H. v. Williams*, 2012 ONCA 35, at para. 26,

there are other interests that may be considered essential components of the “proper administration of justice”, such as access to the courts.

[55] However, as was observed in *Williams*, the focus must be on how the motion is framed. Where the interest in confidentiality engages no public component, the inquiry is at an end. There is no basis upon which to proceed to the second branch of the test where factors such as the nature of the order’s impact on public access and other societal interests become valid considerations.

[56] If the issue relied upon to seek a confidentiality order does involve a public component, the evidence must be carefully examined. The evidence relied upon to satisfy the first branch of the test must be “convincing” and “subject to close scrutiny and meet rigorous standards” [emphasis added by Commissioner Bélanger]; see *R. v. Canadian Broadcasting Corp.*, 2010 ONCA 726, 102 O.R. (3d) 673, at para. 40; *R. v. Toronto Star Newspapers Ltd.* (2003), 67 O.R. (3d) 577 (C.A.), at para. 19, aff’d 2005 SCC 41, [2005] 2 S.C.R. 188, at para. 41; *Williams*, at para. 34; see also *Ottawa Citizen Group Inc. v. R.* (2005), 75 O.R. (3d) 590 (C.A.), at para. 54. This demanding evidentiary standard is in keeping with the well-recognized serious implications of the order.

[57] Pattison framed its need for the sealing order on the basis that disclosure would imperil its commercial interests. The only evidence in support of this assertion is a statement in the affidavit of Randy Otto that the information under seal is “highly sensitive and confidential and can be used by Pattison Outdoor’s competitors, advertisers and land owners to Pattison Outdoor’s disadvantage.”

[58] In my view, this evidence falls short of allowing Pattison to get past the first branch of the *Mentuck* test. There is no indication of how the information could be used against Pattison’s business or how great a risk disclosure would present.

13. The applicants have presented no evidence in any form that the order sought is “necessary to prevent a serious risk to an important interest expressible in terms of a public interest in confidentiality” and indeed have not presented any evidence at all that the order sought is necessary to prevent a serious risk to their own private interests.
14. Absent such evidence, I am unable to conclude that the order sought would be justifiable on any basis.
15. In addition, the Commission’s *Rules on Standing and Funding* make it quite clear that all materials filed in support of a motion for a funding recommendation will be available to the public. The filing of the material in support of the motion for funding was in no way conscripted – it was entirely voluntary.
16. Further, I am unable to agree with the applicants’ contention that the financial information provided “could not possibly assist in determining how the collapse occurred on June 23, 2012.” (paragraph 19 of the original submissions). I am of the opposite view. Proper maintenance of commercial structures is an essential component of structural integrity. Proper maintenance costs money. While it is premature for the Commission to reach any conclusion on the causes of the mall collapse, it is only logical that a careful examination of maintenance procedures of the Algo Mall in the years prior to the collapse be carried out. The nature and extent of these procedures as well as their cost must be carefully investigated and analyzed. In that process, the Mall owners’ financial circumstances are directly relevant and of significant importance.
17. I agree with the submission of the Media Organizations that the “open court” principle is of particular importance in the context of this type of public inquiry “the purpose of which is to

educate the public about the events leading up to a tragedy or worrisome community problem.” (See: *Episcopal Corp. of the Diocese of Alexandria-Cornwall v. Cornwall (Public Inquiry)*, 2007 ONCA 20, at para. 48)

18. My actions and rulings as the officer presiding over this commission must, constantly and of necessity, be subjected to close public scrutiny. Its ultimate findings and recommendations, their merit and their credibility can only be evaluated if its processes are clear and transparent. For that reason, the entire basis that underlies my decision to deny the funding recommendation sought by the applicants must be made evident and palpable. No pertinent evidence or convincing reasons have been advanced to justify departure from that approach. The documents in issue underlie my decision and cannot be withheld from public examination.
19. This application for confidentiality is consequently denied.
20. I make one minor exception to my decision. Some information appears in the documentation provided that is of no relevance to the issues of concern to the Inquiry. Yet, the dissemination of that information might, in an era where identity theft is of great public concern, be prejudicial to the applicants. I refer specifically to Social Insurance Numbers, not only of the applicants appearing in their income tax returns, but also of Robert Nazarian’s spouse. I raised the issue with counsel for the applicants and he, predictably, agreed with my suggestion that he should, as a fallback position, ask for redaction of that information. I believe it would be irresponsible for me to overlook that concern and I did not hear any strong objection at the confidentiality hearing to a selective redaction of that information. Consequently, I direct that any reference to Social Insurance Numbers be redacted before any of the documents in question are made publicly available.

### **The Association of Professional Engineers of Ontario**

21. Section 38 of the *PEA* provides:

#### **Confidentiality**

38.(1) Every person engaged in the administration of this Act, including any person making an examination or review under section 26 or an investigation under section 33, shall preserve secrecy with respect to all matters that come to his or her knowledge in the course of his or her duties, employment, examination, review or investigation and shall not communicate any such matters to any other person except,

- (a) as may be required in connection with the administration of,
  - (i) this Act and the regulations and by-laws, or
  - (ii) the *Architects Act*, and the regulations and by-laws under that Act, or any proceedings under,
  - (iii) this Act or the regulations, or
  - (iv) the *Architects Act*, or the regulations under that Act;
- (b) to his or her counsel; or
- (c) with the consent of the person to whom the information relates. R.S.O. 1990, c. P.28, s. 38 (1).



**Testimony in civil action**

(2) No person to whom subsection (1) applies shall be required to give testimony or to produce any book, record, document or thing in any action or proceeding with regard to information obtained in the course of his or her duties, employment, examination, review or investigation except in a proceeding under this Act or the regulations or by-laws or a proceeding under the *Architects Act* or the regulations or by-laws under that Act. R.S.O. 1990, c. P.28, s. 38 (2).

**22. Subsection 10(3) of the *PIA* provides:**

(3) Subject to the order establishing it and despite any other Act, a commission may require the provision or production of information that is considered confidential or inadmissible under another Act or a regulation and that information shall be disclosed to the commission for the purposes of the public inquiry.

**23. The PEO does not take issue that as between S. 38(1) of the *PEA* and S. 10(3) of the *PIA*, the *PIA* takes precedence; it states that it has produced all relevant documents in its possession to the Commission as it was required to do pursuant to the Commission's summons.****24. The PEO submits that s. 38(1) of the *PEA* operates to obligate the Commission "to ensure that persons to whom information contained in the Confidential Documents relates are given notice of any further use or disclosure of that information that the Commission intends to make and that they be given an opportunity to make submissions as to such intended use or disclosure." To that end, the PEO seeks an order pursuant to ss. 10(4) and 17 of the *PIA* and Rule 17 of the Commission's *Revised Rules of Procedure* that certain named individuals "be given the opportunity to review the Confidential Documents and make submissions as to the appropriateness of any further disclosure and/or use of such documents by the Commission."****25. The PEO also submits that a similar opportunity be given to "anyone else to whom information contained in the Confidential Documents relates." The PEO does not identify these individuals. The summons to PEO was issued on 21 September 2012 and served on 24 September 2012. At the confidentiality hearing of 17 December 2012, I was informed that the PEO had made no effort to identify these unnamed individuals.****26. Nevertheless, the PEO**

"submits that the Commission must exercise the discretion given to it by s. 10(4) of the *PIA* on a principled basis, and after an adjudicative hearing process that is fair to the persons affected. In the PEO's submission, that requires the following steps:

- a. That Commission counsel identify those documents that it believes are irrelevant to the public inquiry and the work of the Commission, and exclude them from consideration;
  - b. That Commission counsel work with the PEO to identify any relevant documents that contain only information that is public in another form, with a view to making them available without restriction or excluding them as duplicative;
  - c. That Commission counsel work with the PEO to identify any person to whom information in the remaining Confidential Documents relates, and who should therefore be given notice of the request to further use or disclose that information;
  - d. That the Commission then make the order proposed in paragraph 8 of these submissions;
- and

e. That the Commissioner receive submissions in writing or hold a hearing or hearings, in camera, on notice to all persons to whom information in the Confidential Documents relates, before making determinations as to the further use or disclosure of such documents, including any conditions or restrictions upon such use or disclosure, under subsection 10(4) of the PIA.”

27. At my direction, Commission counsel undertook to notify the individuals specifically identified in the PEO’s submissions, without acknowledging an obligation to do so. The decision to do so was motivated by my desire for expediency and timeliness.
28. None of the nine named individuals sought to make submissions at the hearing on 17 December 2012.
29. The many documents produced by the PEO contain the names of scores of individuals and organizations who have in one way or another generally been involved in issues related to the mandate of the Commission over five decades.
30. From a practical perspective alone, identifying these individuals, determining their current whereabouts and providing them with notice of a hearing is an unrealistic and virtually impossible task, given particularly the temporal and financial realities with which the Commission must contend.
31. I find it remarkable that the PEO should maintain that a case-by-case, document-by-document examination of produced material be undertaken by the Commission, particularly where PEO in the three-month period before the hearing has not even attempted to do so. The PEO is a legislatively sanctioned body with wide powers over the practice of professional engineering “in order that the public interest may be served.” (See s. 2(3) of *PEA*). Surely, the PEO is in a much better position than the Commission to identify the interests it seeks to protect. These are, after all, its own documents, most of which refer to its own processes.
32. In my opinion, s. 38(1) of the *PEA* in no way relieves PEO from the onus it has of demonstrating why compelling reasons exist for maintaining confidentiality in relation to any particular document. It attempts to shift that burden to the Commission by asserting that it is the Commission’s responsibility to review the documents produced in order to ascertain to whom notice ought to be given. In order to discharge its obligation to serve the public interest, it seems to me, at the very least, that it ought to have engaged in that process in order to make rational and justifiable submissions relating to those who might suffer from the impending potential of publicity.
33. In short, PEO has made no effort to demonstrate the necessity of an order as discussed in *Out-Of-Home (supra)*.
34. I agree with the position of counsel for the Media Organizations that s. 38 of the *PEA* does not make documents themselves confidential but rather operates to prevent specific individuals from sharing documents obtained in the course of an investigation. The Commission is not bound by that limitation.

35. Counsel for Greg Saunders, while supporting PEO's application, presents no evidence to demonstrate the necessity of an order in relation to any specific document. In his submission, he states that "Mr. Saunders supports the PEO's position that he be permitted to review documents not produced by PEO in response to the summons from the Commission" and further that "Mr. Saunders wishes the opportunity to review those documents in the possession or control of PEO that have not been produced or disclosed and are not otherwise itemized or listed by the PEO in its list of documents before taking a position with respect to whether or not those documents should be produced by PEO to the Commission in response to the summons." I obviously am in no position to deal with documents about which I know nothing. In any event, the Commission's *Rules* provide for disclosure of documents intended to be relied upon in relation to any particular witness and more significantly require undertakings from those to whom the documents are provided before the hearings. As well, the *Rules* state that the documents are to be used for no purpose other than Commission proceedings and are not to be disclosed to anyone. S. 12 of the *PIA* provides further statutory protection.
36. Objections to the introduction of any particular document as evidence at the hearings are obviously not foreclosed when made at the appropriate time and for the appropriate reasons.
37. Counsel for Robert Wood submits that should the Commission "not accept the Order proposed by the PEO, it should undertake to balance the probative value of the information contained in the confidential documents with the prejudicial effect on those involved in the documents of the dissemination of the information to the other parties and the public." I acknowledge that obligation but I can only discharge it on the basis of evidence. None has been produced. I also note that there should be no confusion between the investigative and adjudicative functions of the Commission. At the investigative stage, formal relevance and admissibility are not issues. The general criteria employed by Commission counsel at this juncture are apparent responsiveness, importance and materiality of the documents obtained to the issues raised by the Commission's mandate. As mentioned above, at the appropriate time participants such as Messrs. Woods and Saunders will have unrestricted opportunity to object to the introduction into evidence of any material sought to be made exhibits by Commission counsel or counsel for other participants.
38. In the result, the PEO's application is denied.

ISSUED at Ottawa, Ontario, this 8<sup>th</sup> day of January, 2013.

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The Honourable Paul R. Bélanger,  
Commissioner



## Appendix “B”

- Application for Standing and Funding
  - Affidavit of Oliver Fonseca
- Supplementary Submissions on funding
  - Affidavit of Fabio Brussolo
  - Affidavit of Sam Hurmizi
  - Affidavit of Robert Nazarian
- Letters from Michael Title, dated October 26, 2012
- Order to Prohibit Use and Occupancy, dated October 24, 2011
- Contract for the Demolition of the Algo Centre Mall
- Supplementary Submissions on behalf of the Diocese of Alexandria-Cornwall at the Cornwall Inquiry
- Applicants’ Submissions – Requesting a confidentiality order.

### Robert Nazarian – Financial Records

- Canadian Revenue Agency Notice of Assessment – for Robert Nazarian for the tax year of 2011
- Canadian Revenue Agency Income Tax and Benefit Return – T1 General – for Robert Nazarian for the tax year of 2011
- Canadian Revenue Agency Income Tax and Benefit Return – T1 General – for Robert Nazarian for the tax year of 2010
- Canadian Revenue Agency Income Tax and Benefit Return – T1 General – for Robert Nazarian for the tax year of 2009
- Canadian Revenue Agency Income Tax and Benefit Return – T1 General – for Robert Nazarian for the tax year of 2008
- Canadian Revenue Agency Notice of Assessment – for Robert Nazarian for the tax year of 2008
- Canadian Revenue Agency Notice of Re-Assessment for Robert Nazarian for the tax year of 2007
- Financial Information of Yorkdale Group Inc. 2011-2012
- Financial Information of Yorkdale Centre Inc. 2011-2012
- Royal Bank of Canada account statement

### Eastwood Mall Inc. – Financial Statement

- Financial Information of Eastwood Mall Inc. – October 2012
- Letters from BGS Chartered Accountants, LLP, enclosing financial statement – December 2011 and terms of engagement
- Review Engagement Report – Financial Statements – December 31, 2011 (BGS)
- Canadian Revenue Agency – T2 Corporation Income Tax Return, Tax Year 2011
- Financial Statements – December 31, 2010 (Hurmizi & Co.)

### Levon Nazarian – Financial Records

- Canadian Revenue Agency Income Tax and Benefit Return – T1 General – for Levon Nazarian for the tax year of 2011

## M.3 Reasons for Decision and Stated Case re Nazarian

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUETE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

### Reasons for Decision and Stated Case

1. On February 4, 2013, I made the following order:

THIS COMMISSION ORDERS THAT:

1. Robert Nazarian produce to the Commission, forthwith, all documents within his possession, power, or control, described in the summonses to him dated September 6, 2012; September 13, 2012; and December 13, 2012;
2. Levon Nazarian produce to the Commission, forthwith, all documents within his possession, power, or control, described in the summonses to him dated September 27, 2012 and December 13, 2012; and
3. Irene Nazarian produce to the Commission, forthwith, all documents within her possession, power, or control, described in the summons to her dated December 13, 2012.
2. My reasons for making the order, including the facts on which the order is based, are set out below, together with the facts for the stated case pursuant to s. 30(1) of the *Public Inquiries Act*, 2009, S.O. 2009, c. 33, Sch. 6.
3. I have also appended the documentary evidence on which my factual findings are based to these reasons.

### Background

#### *The Commission*

4. On June 23, 2012, the Algo Centre Mall in Elliot Lake, Ontario collapsed, resulting in two deaths and numerous injuries.
5. On July 19, 2012, I was appointed by Order in Council 1097/2012 to conduct an inquiry to:
  - a. Inquire into and report on events surrounding the collapse of the Algo Centre Mall in Elliot Lake, Ontario, the deaths of Lucie Aylwin and Doloris Perizzolo and the injuries to other individuals in attendance at the mall and the emergency management and response by responsible bodies and individuals subsequent to the collapse;

- b. Review relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the structural integrity and safety of the Algo Centre Mall in Elliot Lake, Ontario;
- c. Review relevant legislation, regulations and bylaws and relevant policies, processes and procedures of provincial and municipal governments and other parties with respect to the emergency management and response to the collapse of the Algo Centre Mall in Elliot Lake, Ontario.

***Bob, Levon and Irene Nazarian***

- 6. Robert Nazarian (“Bob”) is a director, president, owner and operator of Eastwood Mall Inc. (“Eastwood”). Eastwood Mall has owned the Algo Centre Mall since 2005. It owned the Algo Centre Mall on the date of the collapse.
- 7. Bob is also:
  - (a) a director and president of Yorkdale Group Inc. From the documents available to the Commission, it appears that Yorkdale Group Inc. was the entity that retained the engineering firm to perform the work that led to a lien being registered on title. In addition, as I noted in my ruling on standing and funding, dated November 8, 2012, Eastwood and Yorkdale Group Inc. appear to be interconnected financially (though the relationship between the two entities was never made clear in Eastwood’s funding application); and
  - (b) president of Algo Hotel Inc., the owner of the hotel that formed part of the Algo Centre Mall.
- 8. Levon Nazarian (“Levon”) is Bob’s son. Levon worked for Eastwood as an independent contractor and administrator, and oversaw the administration of Eastwood’s business transactions, including assisting with the leases and retaining contractors and engineers.
- 9. On November 8, 2012, I granted standing to all of Eastwood, Bob and Levon for Part 1 of the inquiry (which relates to the events prior to the collapse). However, I denied their request for funding because they provided insufficient evidence to suggest that they would not otherwise be able to participate in the inquiry in the absence of receiving such funding.
- 10. Irene Nazarian (“Irene”) is Bob’s wife and Levon’s mother. Although Irene is not a party with standing at the Commission, for the reasons set out below, the Commission is of the view that she has documents in her possession, power or control that are relevant to my mandate.

**The Summonses Issued to Bob, Levon and Irene**

***The Initial Summonses***

- 11. On September 6, 2012, I issued two summonses to produce documents, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Bob in his capacity as president of



Eastwood and as president of Yorkdale Group Inc. The summonses required Bob to produce a series of documents to the Commission by September 20, 2012.

12. That day, on September 6, 2012, Commission Counsel wrote to Derrick Fulton of Steinberg Morton Hope & Israel LLP, who was counsel to Eastwood and Yorkdale Group Inc., enclosing the summonses. Commission Counsel asked Mr. Fulton if he would accept service of the summonses on behalf of Bob.
13. Mr. Fulton responded that day, stating: "Once I have instructions, I will be in touch."
14. On September 13, 2012, I issued a third summons to produce documents, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Bob, this time in his capacity as director of Algo Hotel Inc. The summons required Bob to produce a series of documents to the Commission by September 27, 2012.
15. That day, on September 13, 2012, Commission Counsel wrote to Mr. Fulton, enclosing the third summons. As with his earlier letter, Commission Counsel asked Mr. Fulton to confirm if he would accept service of the summons on behalf of Bob.
16. The Commission did not hear from Mr. Fulton. Accordingly, on September 18, 2012, the Commission served Bob directly with the three summonses.
17. On September 24, 2012, Commission Counsel spoke with Mr. Fulton about the timing of delivery of the materials in response to the summonses that were served on Bob. Mr. Fulton advised Commission Counsel that his office was working on it, and that the Commission could expect to receive the documents in two weeks. He further advised that his clients had approximately 90 to 100 bankers' boxes of materials at the office of Antoine-Rene Fabris (Eastwood's solicitor) in Elliot Lake, and that Mr. Fulton had another couple boxes in his office. Mr. Fulton also asked Commission Counsel about the summons to Yorkdale Group Inc., which Mr. Fulton said had no interest in the Algo Centre Mall. Commission Counsel advised him about the construction lien, which indicated that Yorkdale Group Inc. had retained the lienholder to do work on the mall. Accordingly, Commission Counsel believed that Yorkdale Group Inc. had information about the mall. Mr. Fulton indicated that he would look into the matter.
18. On September 27, 2012, I issued a summons to produce documents, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Levon. The summons required Levon to produce a series of documents to the Commission by October 12, 2012.
19. The next day, on September 28, 2012, Commission Counsel wrote to Levon and enclosed the summons. The letter and summons were served on Levon on October 1, 2012.

***The Documents Received from Mr. Fulton and Mr. Fabris***

20. On October 3, 2012, Mr. Fabris (solicitor for Eastwood) wrote to Commission Counsel respecting the summons that was issued to Levon. Mr. Fabris stated:

Unfortunately all documents that were in the possession of both Levon Nazarian and Robert Nazarian have been seized by the police.

These include each and every file since the date of the purchase including purchase documents that were in their possession. The documents were seized by the police through a valid search warrant and are now in the OPP's possession.

The purpose of this letter is to inform you that while my clients wish to concede to the order; they are unable to and certainly do not wish to face any possible repercussions for not abiding by their terms.

21. On October 10, 2012, Mr. Fulton emailed Yvette Bula, of esi Specialists Inc., with a copy to Commission Counsel. Commission Counsel had retained Ms. Bula to assist with the data management process. In his email to Ms. Bula, Mr. Fulton advised that they had completed the copying of their productions, and only needed "a couple more days". Mr. Fulton further advised that they had "about two banker boxes of material", and that the balance of the materials had been seized by the OPP.
22. That day, Commission Counsel also spoke with Mr. Fulton, who advised that his clients' documents would be produced in two days' time.
23. By October 29, 2012, however, the Commission still had not received any documents from Bob or Levon. Accordingly, that day, Commission Counsel wrote to Mr. Fulton requesting an explanation as to why the production had not yet taken place, and when the Commission would be provided with the documents.
24. On November 7, 2012, Commission Counsel spoke with Mr. Fulton, who advised that his clients' documents were ready to go to the Commission.
25. On or about November 8, 2012, the Commission received one banker's box of documents and one CD containing electronic documents in response to the summonses issued to Bob and Levon. The documents that were produced appeared to have emanated from Mr. Fulton's files.
26. By this time, the Commission appeared to have received conflicting information from Bob and Levon's lawyers (Mr. Fulton and Mr. Fabris) respecting the amount of documents that Bob and Levon had in their possession, power or control, and where those documents were located. In order to ensure that the Commission had all relevant documents in the possession, custody or control of Bob and Levon's lawyers, on November 21, 2012, I issued summonses to produce documents and information, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Mr. Fulton and Mr. Fabris.
27. On November 30, 2012, Mr. Fulton responded to the summons, and confirmed that his office had produced to the Commission all documents in their possession or control.
28. On December 5, 2012, Mr. Fabris produced all documents in his possession that were responsive to the summons. In total, Mr. Fabris produced 84 files from his office to the Commission.

### *The Documents Received from the OPP*

29. Before I issued the initial summonses to Bob or Levon, the Ontario Provincial Police ("OPP") had executed search warrants on the Algo Centre Mall, as well as Bob's residence and business, as part of its investigation into the Algo Centre Mall collapse.
30. The Commission believed that the documents seized by the OPP pursuant to the search warrants were likely relevant to the matters at issue in this public inquiry. Accordingly, on August 29, 2012, I issued a summons, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Commissioner Chris D. Lewis of the OPP to produce (among other things) the documents that the OPP had obtained in connection with its investigation into the Algo Centre Mall collapse.
31. The Commission received documents in response to the summons from the OPP. The documents included data retrieved from three computers that were seized from Bob's residence and one computer from his business.

### *The Additional Summonses*

32. The Commission reviewed the documents received from Mr. Fulton's office, Mr. Fabris' office and the OPP. In the course of that review, the Commission identified numerous email accounts and smartphones that were apparently used by Bob, Irene and Levon to conduct business relating to the Algo Centre Mall.
33. In particular, a review of the available materials revealed:
  - (a) over 4,500 email messages that were sent to and received from (among other email addresses) [nazariani@rogers.com](mailto:nazariani@rogers.com);
  - (b) use of webmail user accounts with the following email addresses:
    - [bob@yorkdalegroup.com](mailto:bob@yorkdalegroup.com)
    - [levon@levon-pm.com](mailto:levon@levon-pm.com)
    - [levon@remaxinfinite.com](mailto:levon@remaxinfinite.com)
    - [nazarianb@rogers.com](mailto:nazarianb@rogers.com)

However, because the email accounts were webmail accounts, the email messages from these accounts were not stored on the computers. As a result, although the Commission was able to identify that the webmail addresses were used, Commission staff were unable to access the emails from those accounts; and

- (c) use of several smartphones (Blackberry and Android). Again, while the Commission was able to identify that smartphones were used, Commission staff were unable to access the data that was sent to or received from those devices.



34. As a result of the foregoing, it became apparent to me that Bob and Levon had relevant documents in their possession, power or control that had not been produced, in contravention of the initial summonses that I had issued to them. In addition, the Commission’s review of the emails that it was able to retrieve suggested that Irene did work for Eastwood, including paperwork and human resources related tasks for the company.
35. Accordingly, on December 6, 2012, I issued further summonses to produce documents, pursuant to s. 10(1)(b) of the *Public Inquiries Act, 2009*, to Bob, Irene and Levon (the “Additional Summonses”). The Additional Summonses required Bob, Irene and Levon to produce the following (among other things) by December 14, 2012:
  1. All emails, including attachments, relating to the Algo Centre Mall, including but not limited to emails sent or received to the following email and/or webmail addresses:
    - a. bob@yorkdalegroup.com;
    - b. levon@remaxinfinite.com;
    - c. levon@levon-pm.com;
    - d. nazarianb@rogers.com;
    - e. nazariani@rogers.com.
  2. All emails, including attachments, and documents relating to the Alga Centre Mall, including but not limited to emails or messages sent or received using the following smartphones:
    - a. HTC Android Phone;
    - b. RIM Blackberry.
36. The Commission served the Additional Summonses on Bob and Irene on December 11, 2012, and on Levon on December 12, 2012.
37. On December 12, 2012, Commission Counsel wrote to Michael Title, Mr. Fulton’s partner at Steinberg Morton Hope & Israel LLP. In the letter, Commission Counsel provided some context for the Additional Summonses. With respect to the request for emails, Commission Counsel noted that, while Mr. Title’s clients no longer had possession of the computers they used, they should be able to obtain copies of the emails through their webmail accounts and/or through their service providers.
38. The next day, December 13, 2012, Mr. Fulton wrote to Commission Counsel, indicating that the deadline of December 14, 2012 was “certainly unreasonable and near impossible, particularly given the fact that we need to make requests from third parties”.
39. The following day, December 14, 2012, Commission Counsel responded to Mr. Fulton’s letter. In the letter, Commission Counsel indicated that the Commission was prepared to

extend the deadline for delivery of the documents to December 21, 2012, “as long as you provide us, today, with a copy of your requests to the third parties seeking the documents which are the subject of the Summonses”.

40. The Commission did not receive any response to this letter.
41. On January 3, 2013, Commission Counsel spoke with Mr. Title. They discussed, among other things, the failure by Mr. Title’s clients to comply with their legal obligations, and in particular, their lack of response to the Additional Summonses. Commission Counsel and Mr. Title discussed ways to resolve the issue, including by having the data management company that the Commission had retained search Bob, Levon and Irene’s emails for relevant keywords.
42. In the meantime, the Commission continued with its review of the documents that it had received from Mr. Fulton’s office, Mr. Fabris’ office and the OPP, including the emails that were recovered from the seized computers. In the course of that review, the Commission identified additional email accounts that were used by employees of Eastwood. On December 19 and 20, 2012, I issued summonses to those employees to produce all relevant documents, including emails from the email accounts that were identified. The employees responded, however, that they no longer had access to their respective email accounts.
43. Accordingly, on January 8, 2013, Commission Counsel wrote to Mr. Title as follows:

Since issuing the three Summonses against Robert, Levon and Irene Nazarian on December 6, 2012, it has come to the attention of the Commission that the following additional email and/or webmail addresses were also used by employees of East wood Mall Inc.

- [eastwood.mall@yahoo.ca](mailto:eastwood.mall@yahoo.ca);
- [pam@algocentremall.com](mailto:pam@algocentremall.com);
- [gwen@algocentremall.com](mailto:gwen@algocentremall.com);
- [ann@algocentremall.com](mailto:ann@algocentremall.com);
- [shannon@algoinn.com](mailto:shannon@algoinn.com);
- [rhonda@algocentremall.com](mailto:rhonda@algocentremall.com)

In this regard, the Commission has served Summonses on Pam Folkes, Gwendlyn (Gwen) Goulet, Ann Sabourin, Shannon Brown and Rhonda Lendt. We have been advised by Ms. Folkes, Ms. Sabourin, Ms. Brown and Ms. Lendt that they no longer have access to their respective email addresses above. We understand that the domain name @algocentremall.com is owned by your client Levon Nazarian, as per the GoDaddy WHOIS information attached.

Similarly to the email and/or webmail addresses outline[d] in the December 6, 2012 Summonses, the Commission requires your clients to produce all emails, including

attachments, sent or received to the above-noted email and/or webmail addresses and any other email and/or webmail addresses of any other employee of Eastwood Mall Inc. in relation to the Algo Centre Mall. Production of these emails is required by the Summonses which were served on your clients, which required production of all emails in the possession, power and control of your clients in relation to the Algo Centre Mall.

Should you have any questions, please do not hesitate to contact me.

44. The Commission received no response to this letter.
45. On January 25, 2013, Commission Counsel wrote again to Mr. Title respecting his clients' non-compliance with the summonses that were issued to them. Commission Counsel indicated that if the documents were not produced by February 1, 2013, they would consider all of their options, including an application to the Commissioner for an order pursuant to s. 29(b) of the *Public Inquiries Act, 2009*.
46. On January 31, 2013, Mr. Fulton responded. He wrote:

We have a dedicated Articling Student on this matter and she is currently and actively still gathering up the requested information. This process is taking significantly longer than we ever expected. This request is not simply to hand over documents in our possession. These are documents with third party service providers and we are finding this process less than straightforward. We would like to give you a certain date as to when you will have this information but unfortunately we cannot. We are working on it as fast as we can and we will contact you by next Wednesday to provide an update.

47. The next day, February 1, 2013, Commission Counsel responded to Mr. Fulton's letter. Commission Counsel made the following request:

We would ask that you immediately provide us with copies of the documents that you have gathered so far and the written requests that you, or your clients, have made to the third party service providers requesting the documents sought by the Commission. I note that I had asked you, on December 14, 2012, for a copy of these requests. You never provided them to the Commission. If I do not receive, by the end of the day today, the documents you have so far gathered and the requests to third parties, we will consider our options as outlined in my letter of January 25, 2013.

48. The Commission did not receive a response to this letter.

#### **Reasons and Facts for Stated Case**

49. In light of these facts and Bob, Levon and Irene's continued non-compliance with the summonses that were issued to them, on February 4, 2013, I made the order set out above, pursuant to s. 29(b) of the *Public Inquiries Act, 2009*.
50. There is no question that Bob and Levon are essential participants in this public inquiry. As I stated in my ruling on standing and funding, dated November 8, 2012:



Eastwood Mall Inc. owned the Algo Centre Mall from 2005 to the present date, including on the date of the collapse. The Notice of Application and accompanying submissions assert that Robert Nazarian is a director, President, owner and operator of Eastwood Mall Inc.; Levon Nazarian, his son, worked for Eastwood Mall Inc. as an independent contractor and administrator; and Levon Nazarian oversaw the administration of Eastwood Mall Inc.'s business transactions, including assisting with the leases and retaining contractors and engineers.

This corporation and these individuals are directly connected to the ownership and management of the Mall at the time of the collapse. They are the object of a number of investigations. They submit that they anticipate receiving notices pursuant to Section 17 of the *Public Inquiries Act, 2009*. They clearly have a significant, substantial and direct interest. They have requested standing in relation to **Part 1** of the Inquiry and standing is **granted** as requested.

51. The public hearings in this inquiry commenced on March 4, 2013. The documents at issue are relevant, if not essential, to the fulfillment of my mandate and the efficient conduct of the public hearings.
52. Having applied for and obtained standing at this inquiry, it is incumbent upon Bob and Levon to comply with the summonses issued to them. In the Additional Summonses and subsequent correspondence, the Commission identified a series of email accounts that are in the possession, power or control of Bob and Levon. Despite numerous requests, Bob and Levon have not produced the emails relating to the Algo Centre Mall from those email accounts. Nor have they produced any evidence to the Commission to confirm that the requests for emails from third party service providers have even been made. Instead, throughout the documentary production process, they have shown disregard for the timelines set out in the summonses that I have issued, the reasonable requests of Commission Counsel, and now, my order of February 4, 2013. They appear to be of the view that they can produce what they want, when they want.
53. While Irene is not a party with standing at this inquiry, for the reasons set out above, the Commission is of the view that she has possession, power or control of the documents identified in the summons dated December 6, 2012 (and in particular, emails from her Rogers email account), all of which are relevant to my mandate. Indeed, the Commission received no indication from Irene or her counsel to suggest otherwise.
54. For the reasons set out above, on February 4, 2013, I made the order requiring production "forthwith" of the documents identified in the various summonses described above.

ISSUED at Ottawa, Ontario, this 6th day of March, 2013.

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The Honourable Paul R. Bélanger  
Commissioner

**Appendices to Reasons for Decision and Stated Case**

<b>TAB</b>	<b>DOCUMENT</b>
<b>A</b>	Summons to Produce Documents to Commissioner Chris D. Lewis, Ontario Provincial Police, dated August 29, 2013
<b>B</b>	Letter from Commission Counsel to Derrick Fulton, dated September 6, 2012, enclosing: <ul style="list-style-type: none"> <li>• Summons to Produce Documents to Robert Nazarian, President, Eastwood Mall Inc., dated September 6, 2012</li> <li>• Summons to Produce Documents to Robert Nazarian, President, Yorkdale Group Inc., dated September 6, 2012</li> </ul>
<b>C</b>	Emails between Peter Doody and Derrick Fulton, dated September 6, 2012
<b>D</b>	Letter from Commission Counsel to Derrick Fulton, dated September 13, 2012, enclosing: <ul style="list-style-type: none"> <li>• Summons to Produce Documents to Robert Nazarian, Director, Algo Hotel Inc., dated September 13, 2012</li> </ul>
<b>E</b>	Affidavit of Service of Gaetano T. Pampalone, sworn September 21, 2012
<b>F</b>	Letter from Commission Counsel to Levon Nazarian, dated September 28, 2012, enclosing: <ul style="list-style-type: none"> <li>• Summons to Produce Documents to Levon Nazarian, dated September 27, 2012</li> </ul>
<b>G</b>	Affidavit of Service of Leo Pereira, sworn October 3, 2012
<b>H</b>	Letter from Antoine-René Fabris to Commission Counsel, dated October 3, 2012
<b>I</b>	Emails between Yvette Bula, Peter Doody and Derrick Fulton, dated September 24 and October 10, 2012
<b>J</b>	Letter from Commission Counsel to Derrick Fulton, dated October 29, 2012
<b>K</b>	Emails between Derrick Fulton and Mark Wallace, dated November 7 and 8, 2012
<b>L</b>	Letter from Derrick Fulton to Commission Counsel, c/o of esi Specialists Inc., dated November 8, 2012
<b>M</b>	Letter from Commission Counsel to Derrick Fulton, dated November 8, 2012

TAB	DOCUMENT
N	<p>Letter from Commission Counsel Derrick Fulton, dated November 21, 2012, enclosing:</p> <ul style="list-style-type: none"> <li>• Summons to Produce Documents and Information to Derrick Fulton, dated November 21, 2012</li> </ul>
O	<p>Letter from Commission Counsel to Antoine-René Fabris, dated November 21, 2012, enclosing:</p> <ul style="list-style-type: none"> <li>• Summons to Produce Documents and Information to Antoine-René Fabris, dated November 21, 2012</li> </ul>
P	Letter from Derrick Fulton to Commission Counsel, dated November 30, 2012
Q	<p>Letter from Antoine-René Fabris to Commission Counsel, dated December 5, 2012, enclosing:</p> <ul style="list-style-type: none"> <li>• Index of Documents Produced by Brown &amp; Fabris Law Office</li> <li>• Statutory Declaration of Antoine-René Fabris, dated December 5, 2012</li> </ul>
R	<p>Letter from Commission Counsel to Michael Title, dated December 12, 2012, enclosing:</p> <ul style="list-style-type: none"> <li>• Summons to Produce Documents to Robert Nazarian, dated December 6, 2012</li> <li>• Summons to Produce Documents to Levon Nazarian, dated December 6, 2012</li> <li>• Summons to Produce Documents to Irene Nazarian, dated December 6, 2012</li> <li>• Letter from Darrell Kloeze to Eastwood Mall Inc., dated October 24, 2012</li> <li>• Printouts from webmail “inboxes” for bob@yorkdalegroup.com, levon@remaxinfinite.com, and levon@levon-pm.com</li> </ul>
S	Affidavits of Service of Guy Pampalone, sworn December 13, 2012
T	Letter from Derrick Fulton to Commission Counsel, dated December 13, 2012
U	Letter from Commission Counsel to Derrick Fulton, dated December 14, 2012
V	Letter from Commission Counsel to Derrick Fulton, dated December 18, 2012



TAB	DOCUMENT
<b>W</b>	Letter from Commission Counsel to Rhonda Lendt, dated December 19, 2012, enclosing: <ul style="list-style-type: none"> <li>Summons to Produce Documents to Rhonda Lendt, dated December 19, 2012</li> </ul>
<b>X</b>	Letter from Commission Counsel to Shannon Brown, dated December 19, 2012, enclosing: <ul style="list-style-type: none"> <li>Summons to Produce Documents to Shannon Brown, dated December 19, 2012</li> </ul>
<b>Y</b>	Letter from Commission Counsel to Ann Sabourin, dated December 20, 2012, enclosing: <ul style="list-style-type: none"> <li>Summons to Produce Documents to Ann Sabourin, dated December 20, 2012</li> </ul>
<b>Z</b>	Letter from Commission Counsel to Gwendlyn Goulet, dated December 20, 2012, enclosing: <ul style="list-style-type: none"> <li>Summons to Produce Documents to Gwendlyn Goulet, dated December 20, 2012</li> </ul>
<b>AA</b>	Letter from Commission Counsel to Pam Folkes, dated December 20, 2012, enclosing: <ul style="list-style-type: none"> <li>Summons to Produce Documents to Pam Folkes, dated December 20, 2012</li> </ul>
<b>BB</b>	Email from Ann Sabourin to Peter Doody, dated December 27, 2012
<b>CC</b>	Email from Pamela Folkes to Elliot Lake Commission of Inquiry, dated December 31, 2012
<b>DD</b>	Email from Shannon Brown to Peter Doody, dated January 1, 2013
<b>EE</b>	Email from Rhonda Lendt to Yvette Bula, dated January 3, 2013
<b>FF</b>	Letter from Commission Counsel to Michael Title, dated January 3, 2013
<b>GG</b>	Letter from Commission Counsel to Michael Title, dated January 8, 2013, with enclosure
<b>HH</b>	Email from Gwendlyn Reed to Elliot Lake Commission of Inquiry, dated January 9, 2013
<b>II</b>	Letter from Commission Counsel to Michael Title, dated January 25, 2013

TAB	DOCUMENT
JJ	Letter from Derrick Fulton to Commission Counsel, dated January 31, 2013
KK	Letter from Commission Counsel to Derrick Fulton, dated February 1, 2013

859771\_1.DOC

## M.4 Ruling on motion by James Keywan to call an expert witness

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

### Ruling on the Motion of James Keywan in respect of the Report of Allan Larden

1. On June 21, 2013, John Brunner, counsel for James Keywan, filed a motion and supporting materials in which Mr. Keywan is seeking an Order granting him the right to introduce rebuttal evidence at the Inquiry pursuant to Rule 31 of the Commission's Rules of Procedure and section 17.1(b) of the *Public Inquiries Act, 2009* (the "Keywan Motion"). Specifically, Mr. Keywan is seeking to introduce a report of Allan Larden dated May 14, 2013 (the "Larden Report").
2. On June 24, 2013, counsel for Elliot Lake Mall Action Committee ("ELMAC") submitted responding materials in which it opposed the filing of the Larden Report or permitting Mr. Larden to testify at the Inquiry.
3. By email dated June 26, 2013, Commission Counsel advised Counsel and the Participants that I intended to determine the Keywan Motion on the basis of written submissions. Commission Counsel further advised that if any other Participants wished to make written submissions they were invited to do so by no later than July 5, 2013. The only submissions in respect of the Keywan Motion received by the Commission were those submitted by ELMAC.

#### The Keywan Motion

4. I have carefully reviewed the submissions of counsel for Mr. Keywan as well as those of ELMAC, and I have concluded that Mr. Keywan will be given the right to file the Larden Report. All Participants, section 17 recipients and Commission Counsel will be given the

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info@elliottlakeinquiry.ca

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right to cross examine Mr. Larden. Unless I or Commission Counsel subsequently indicate otherwise, Mr. Larden will be called to testify before the Inquiry on July 29, 2013 (and 30<sup>th</sup> if necessary).

5. Simply put, I note that:

- a) I am not bound to accept or reject any or all of the observations and conclusions reached in either of the Larden or the NORR Reports. In that respect I will be guided by the Participants' eventual submissions.
- b) At this stage of the proceedings of the Commission, I am not prepared to be constrained or restricted in arriving at the findings and conclusions encompassed by my mandate.
- c) Throughout this Inquiry, I have been and will continue to be mindful of my obligations arising out of:
  - i) The Order-in-Council establishing this Inquiry dated July 19, 2012;
  - ii) This Inquiry's Rules of Procedure; and
  - iii) *Public Inquiries Act, 2009*, S.O. 2009, c. 33, Sched. 6.
- d) I am sensitive to counter any perception of unfairness to any Participant or section 17 recipient constrained to appear to give evidence before the Commission or to those who have the right to cross examine.

ISSUED at Elliot Lake, Ontario, this 15<sup>th</sup> day of July, 2013.

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The Honourable Paul R. Bélanger,  
Commissioner

## M.5 Ruling by Justice Goudge on privilege claims

June 28 2013

In the Matter of an Application Under Rule 11(c) of the *Rules of Procedure* of the  
Elliot Lake Commission of Inquiry

BETWEEN

The Elliot Lake Commission of Inquiry

Applicant

and

Paul Mand

Respondent

and

The Elliot Lake Commission of Inquiry

Applicant

and

Eastwood Mall Inc., Robert Nazarian, Irene Nazarian and Levon Nazarian

Respondents

**Goudge J.A.:**

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[1] The Elliot Lake Commission of Inquiry was established on July 19, 2012 under the *Public Inquiries Act 2009*, S.O. 2009, c. 33, Sched. 6.

[2] Rule 11 of its *Rules of Procedure* addresses the procedure for asserting and determining claims of privilege for documents sought by Commission Counsel. It reads:

Where a participant or summons recipient objects to the production of any document, or part thereof, on the grounds of privilege, pursuant to subsection 8(3) of the Act, the following procedures will apply:

- a. The participant or summons recipient shall deliver to Commission Counsel a list setting out pertinent details of the document(s), or part thereof, over which claims for privilege are being asserted. This shall include the date, author, recipient and a brief description of the document(s), and may include additional material, such as an affidavit, to support its claims;
- b. Commission Counsel shall review the list and decide if they will recommend to the Commissioner that he accept the claim for privilege;
- c. If Commission Counsel are not prepared to recommend to the Commissioner that he accept the claim for privilege, the list and any further material file by the participant or summons recipient shall be submitted forthwith, together with Commission Counsel's written submissions, to the Commissioner or, at the Commissioner's option, to the Honourable Stephen T. Goudge, Justice of the Ontario Court of Appeal, for



Page: 3

determination. If the Commissioner or Justice Goudge is unable to make a determination based on the record before them, they may request a copy of the disputed document(s) for inspection; and

d. If the claim for privilege is dismissed, the document(s) shall be produced to Commission Counsel forthwith.

[3] Pursuant to that Rule, two applications have been made to me by Commission Counsel. The first concerns documents in the possession of the respondent Paul Mand, the managing partner of Mand Rai LLP Lawyers, formerly the lawyers for the Algo Centre Mall and for Eastwood Mall Inc., owners of the Algo Centre Mall at the time of the collapse. The second application concerns documents in the possession of the respondents Eastwood Mall Inc., its President Robert Nazarian, his wife, Irene Nazarian and his son, Levon Nazarian, who worked for Eastwood Mall Inc.

[4] For each application, I have received and reviewed Application Records and a Factum and Reply Factum of Commission Counsel, and a responding Application Record from the respondents.

[5] The legal principles I propose to apply in making my determination of these applications are straightforward and uncontested:

- a. The party asserting the privilege must establish an evidentiary base for it.

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- b. Solicitor-client privilege applies to a communication between solicitor and client which entails the seeking or giving of legal advice and is intended to be confidential by the parties.
- c. This privilege extends to a third party where the third party serves as a channel of communication between the client and the solicitor and the communication otherwise meets the criteria for the existence of the privilege.
- d. Litigation privilege applies to a communication created for the dominant purpose of litigation, actual or reasonably contemplated, whether the communication is between lawyer and client or lawyer and third party.
- e. Settlement privilege applies to a communication made to bring about settlement of actual or reasonably contemplated litigation and that is made with the intention that it not be disclosed if settlement negotiations fail.

[6] With these principles in mind, I turn to the particulars of the two applications.

### **The Mand Application**

[7] This application concerns 26 documents for which solicitor-client privilege is claimed, 31 documents for which litigation privilege is claimed, and 4

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documents not produced because the respondent says they are in the public record.

[8] For the 26 documents for which solicitor-client privilege is asserted, the respondent says simply that they are communications made in confidence “regarding the matter of my client” “for the purposes of providing legal advice”. In my view, for the reasons that follow, I would not sustain the claim for privilege, except as set out below.

[9] A number of documents in this group appear to have been prepared by a third party. There is no showing that the third party was serving as a conduit for or interpreter of information for the purpose of legal advice, and hence no basis to extend the privilege to them. In Schedule A of Commission Counsel's Factum this applies to documents 1, 2, 5, 6, 8, 9, 10, 11, 17, 18, 24, 25, 26, 27, 28, 31, 36, 37 and 38.

[10] For documents 7, 12 and 13, the creator would appear not to be either the lawyer or the client but an unknown person for an unknown purpose. That is not enough.

[11] Document 15 is a final contract with a third party and therefore not confidential to the solicitor and client.

[12] Document 39 consists of a letter from another lawyer representing the same client and an accompanying document prepared by a third party. The letter



Page: 6

from the other lawyer is privileged, but the remainder of document 39 is not privileged. Document 40 is a communication to another lawyer (representing another party to litigation) and thus not confidential.

[13] Of this group, document 14 could be said to qualify for the privilege. While its author is unknown, it appears to have been given by the client to the lawyer for the purposes of receiving legal advice about that very document. In addition, put beside document 15 it may be that the legal advice given about it could be inferred. Taking into account both considerations, I would therefore determine that the privilege should extend to it.

[14] In summary, the only materials protected by solicitor-client privilege are document 14 and the portion of document 39 that is a letter from the client's other lawyer.

[15] For the 31 documents for which litigation privilege is asserted, the respondent says that they are communications made in drafting a statement of defence and cross-claim in the action of 1204112 Ontario Inc., et al. In my view, it has not been established that any of these documents attract this privilege. All but one (document 4 of Schedule "C" to Commission Counsel's Factum) are communications with the lawyer for the opposite party in the litigation, which does not qualify. The one exception does not qualify either because there is nothing to show that it was created for a litigation purpose.

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[16] Finally, in this application there are 4 documents that the respondent declines to produce because he says they are available in the public record. This is not a basis to claim privilege for them and I would so find.

**The Nazarian Application**

[17] This application involves 289 documents. For 144 of these, the respondents claim solicitor-client privilege. For the other 145 documents, the respondents claim litigation and/or settlement privilege.

[18] The group of documents that raise the issue of solicitor-client privilege can conveniently be dealt with in subgroups. I will identify the documents in each subgroup using the number attached to them by Commission Counsel in the far left column of Schedule C3 of the Reply Factum.

[19] The first subgroup consists of communications involving one of the respondents, the lawyer and a third party accountant. Some of these communications are between only two of these and some appear also to be copied to the third. These communications are listed in Appendix A to these reasons.

[20] There is no doubt that in the right circumstances solicitor-client privilege can extend to a third party accountant. However, the only justification offered here for the extension of the privilege is found in a schedule to the affidavit of the respondents' present solicitors in the responding Application Record. For each

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document the very brief reason given for solicitor-client privilege is only that the third party is the client's accountant and the information is being given to and by the accountant as agent for the purpose of obtaining legal advice.

[21] For present purposes, I am prepared to accept these assertions as factual. Nonetheless, I cannot conclude that this cryptic explanation warrants a finding that these communications are subject to solicitor-client privilege. There is no assertion by the respondents that the third party accountant was serving as a channel of communication between the respondents and their lawyer. Nor is there any assertion that these were communications where the third party was employing an expertise in assembling information provided by the client in order to explain that information to the lawyer. Nor is it enough that the accountant was described as an agent of the client. In this connection, see *General Accident Assurance Co. v. Chrusz* (1999), 45 O.R. (3d) 321 (C.A.) *per* Doherty J.A. at 356. I cannot conclude that a description such as this, that leaves so much to the imagination, allows the conclusion that the third party was authorized by the respondents to obtain legal advice for them or relay such advice to them. I cannot say that the third party's function was essential to the maintenance of or operation of the solicitor-client relationship.

[22] The second subgroup consists of communications involving one of the respondents, the lawyer and a third party such as a demolition firm, and an



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assistant land surveyor or real estate agent. These communications are listed in Appendix B.

[23] Once again, the only justification for the privilege claimed is the bald assertion that the information in the communication was given to and by the third party as agent for the client for the purpose of obtaining legal advice. As with the first subgroup, I would dismiss the claim for privilege and for the same reasons, but with an additional rationale. Unlike the accountant subgroup, there is nothing inherent in the skill set of these third parties that would seem to equip them to possibly gather information provided by the client and explain it to the lawyer. Rather, their expertise would seem to rest with gathering information from sources extraneous to the client and passing it on as was the case with the third party in *Chrusz, supra*. This does not trigger the privilege.

[24] The third subgroup for which solicitor-client privilege is claimed consists of communications to or from one of the respondents, from or to another respondent or a third party, forwarding what is described simply as a communication between client and counsel. These are listed in Appendix C.

[25] I would dismiss this claim for privilege because there is no showing that the communication forwarded was for the purpose of legal advice, a fundamental pre-condition for the privilege.

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[26] The fourth subgroup consists of communications to or from a respondent, from or to a third party, where the rationale for the privilege claimed is that counsel was copied for the purpose of providing legal advice. These are listed in Appendix D.

[27] I would deny this claim because of the involvement of the third party. Although the third party has an email address of "algocentremall.com" there is nothing to show that the third party acted as an agent of a respondent rather than a stranger to the proceedings. The solicitor-client privilege cannot be extended to communications involving such a third party.

[28] The fifth subgroup is made up of communications between a respondent and counsel that the respondent forwards to his alternate email account. These are listed in Appendix E.

[29] The only reason offered for the privilege here is that the forwarded communication is between the respondent and counsel. Unfortunately that is not enough to sustain the claim. There is no assertion, even a bald one, that the forwarded communication was for the purpose of legal advice.

[30] The sixth subgroup consists of communications between two of the respondents forwarding communication between counsel and the respondent that was sent for the purpose of legal advice. These are listed in Appendix F.

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[31] I would accord privilege to these communications. The respondents appear all to be clients of counsel in the same matter. In my view, communications with each other relaying communications with counsel and one of them which are privileged to that client must also be privileged to the other client. As the Rules of Professional Conduct of the Law Society of Upper Canada make clear, nothing can be confidential as between clients where counsel has a joint retainer.

[32] The final subgroup consists of communications between another counsel and a respondent where this counsel was said to be acting for the respondent and the communications otherwise met the requirements for the privilege. I am prepared to accept that these communications involved legal advice to the respondent and were intended to be confidential. I would therefore allow the claim. These documents are listed in Appendix G.

[33] The respondents' claim for litigation and/or settlement privilege concerns 145 documents. The respondents say that all were created in contemplation of an action the respondents commenced against Zurich Insurance Company Ltd. on June 17, 2013. These documents are listed in Appendix G.

[34] There are two difficulties with the litigation privilege claim. First, the respondents assert only that the communication said to be covered by the privilege were in contemplation of litigation. That does not go far enough. The




Page: 12

communications must be created for the dominant purpose of litigation. Second, the communications must be created at a time when the Zurich litigation was a reasonable prospect. In my view, there is no information from the respondents to indicate when or why the Zurich litigation became a reasonable prospect. The bald assertion made by the respondents does not suffice, particularly given that some of the communications significantly predate the litigation and indeed the mall collapse itself to which the litigation may relate. I would therefore dismiss the claim for litigation privilege.

[35] The claim for settlement privilege also suffers from two fatal flaws. First, there is nothing shown that would meet the requirement that the communications were made with the intention that they would not be disclosed in the event that settlement negotiations failed. Second, for the same reasons I indicated in the context of the claim for litigation privilege, I do not think that the respondents have shown enough in these circumstances to demonstrate that these communications originated at a time when the Zurich litigation was in reasonable contemplation. I conclude therefore that settlement privilege does not apply to these communications.

[36] In summary, my determination is that none of these 145 documents are subject to litigation and/or settlement privilege.



Appendix A

39	520
90	522
91	524
92	528
104	544
109	545
110	583
111	584
114	599
115	600
116	601
117	602
121	603
370	621
371	624
374	705
377	713
378	776
379	777
380	1142
402	1143
403	1177
409	1178
572	1243
573	1395
2409	1396
413	1411
414	2035
415	2037
466	2038
467	2219
468	2228
469	2317
471	2321
472	2326
473	2436
486	2438
498	

Appendix B

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462
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533
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Appendix C

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Appendix D

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Appendix E
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1101
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Appendix F
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Appendix G
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2523
2525
2537

Appendix H			
46	504	680	1866
47	507	681	2082
48	508	682	2116
85	509	683	2140
177	510	684	2153
310	511	685	2154
311	512	686	2155
362	513	687	2168
364	514	688	2169
365	515	689	2201
369	519	690	2202
408	526	691	2203
555	527	701	2217
556	531	711	2244
565	532	712	2245
566	535	737	2249
567	539	738	2256
570	541	751	2261
574	546	752	2266
575	547	753	2272
576	548	754	2277
2399	577	758	2283
421	578	766	2290
430	579	767	2291
453	581	768	2293
454	582	775	2294
455	589	791	2295
464	593	796	2296
479	595	797	2297
483	596	799	2304
484	597	813	2308
485	612	844	2333
488	613	1182	2349
496	638	1183	2368
497	650	1184	
499	651	1864	
501	679	1865	



## M.6 Ruling on the application by Robert Wood

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUETE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

## Ruling on the Application by Robert Wood

### A. Introduction

1. Robert Wood, a Participant in this Inquiry, applies before me for an order that the final Report of this Commission be redacted. Specifically, Mr. Wood asks that:
  - a. the Final Report of the Elliot Lake Commission be redacted to ensure that the Applicant's right to a fair trial pursuant to the *Canadian Charter of Rights and Freedoms* be protected;
  - b. the redaction include only passages that deal with the matter of the Applicant's Section 17 notice as provided to the Applicant pursuant to the *Public Inquiries Act, 2009*; and further,
  - c. the said redaction be removed from the Final Report of the Commission immediately following the event of:
    - i. The Applicant electing a trial of the *Criminal Code* matters before an Ontario Court of Justice;
    - ii. The Applicant electing a trial of the *Criminal Code* matters before a judge sitting without a jury;
    - iii. The Applicant or the prosecutor requests a preliminary hearing following the Applicant electing to be tried before a court comprised of a judge sitting with a jury and the Applicant is not committed to stand trial following the completion of the preliminary hearing; or
    - iv. The Applicant is acquitted or convicted following the trial of the Applicant before a judge sitting with a jury.
2. The Canadian Broadcasting Corporation, The Globe and Mail Inc. and Canadian Press Enterprises Inc. (collectively the "Media Organizations"), the Province of Ontario, the Ontario Building Officials Association ("OBOA"), and Commission Counsel filed written submissions and, except for the OBOA, chose to make oral submissions at the hearing of the Application on June 20, 2014.
3. Stated succinctly, the Media Organizations submit that the Commission lacks jurisdiction to grant Mr. Wood's request and that even if it has jurisdiction, Mr. Wood has not met the evidentiary or legal burden required "to displace the presumption of openness that attaches to all aspects of public inquiries."

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4. The Province of Ontario submits that I have the jurisdiction to redact my findings prior to the delivery of my Report to the Attorney General but takes no position on the substance of Mr. Wood's Application.
5. The OBOA takes the position that I have no "authority respecting any aspect of the public disclosure of the Final Report" and that I am simply to "have it printed and delivered to the Attorney General." The OBOA submits that "an amendment or clarification of the Commission of Inquiry's Terms of Reference be made" to permit me to:
  - a. release the Inquiry's Final Report to the public on a date, at a location and in a manner chosen by the Commissioner;
  - b. pre-release, within a prescribed period and only to those Inquiry Participants requesting, his Final Report in a confidential or "lock-up" manner; and
  - c. convene a public meeting to deliver a statement, issue a press release and conduct a press conference respecting the Final Report's findings and recommendations.
6. Commission Counsel properly takes no position on Mr. Wood's application. Counsel's submissions are limited to providing me with the law applicable to the issues raised by the Application.
7. I am not aware of any jurisprudence involving a situation where the commissioner of a public inquiry has been asked to redact the anticipated report by selectively blanking out portions dealing with one of many actors in a long and complex narrative because criminal charges are pending and where the applicant has given evidence without objection or seeking a publication ban. All of the cases I have been referred to involve either objections to the compellability of persons charged with criminal offences, deferral of the entire commission report until criminal charges have been disposed of, publication bans on the contents of informations to obtain, or challenges to statutory prohibitions.
8. I am asked to redact my Report of the conclusions and opinions relating to the Applicant's actions or his credibility. I note, as I discuss below, that all of the evidence has been heard by the Commission and published on its website.
9. For the reasons that follow, I reject the argument that I have no jurisdiction to order the redaction of my Report. However, I deny Mr. Wood's Application. I choose not to respond to the OBOA's submissions which, in any event, extend beyond my powers and to some degree, ask for a remedy that is inconsistent with the *Public Inquiries Act, 2009*.<sup>1</sup> It also does not address Mr. Wood's Application.

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<sup>1</sup> S.O. 2009 c. 33, Sch. 6.

## B. Jurisdiction of the Commission to Grant the Orders Sought

10. I agree with the Media Organizations that public inquiries do not have inherent jurisdiction. My powers are derived and circumscribed by the *Public Inquiries Act, 2009*<sup>2</sup> and the Order in Council creating the Commission. Indeed, s. 5 of the *Public Inquiries Act, 2009*,<sup>3</sup> provides that a Commission shall “conduct its public inquiry faithfully, honestly and impartially in accordance with its terms of reference.”

11. I also agree with the Media Organizations that s. 14(3) of the *Public Inquiries Act, 2009*,<sup>4</sup> relied upon by Mr. Wood as the source of my authority, appears to have the conduct of hearings as its object when it provides that:

**14. (3)** A commission may exclude the public from all or part of a hearing or take other measures to prevent the disclosure of information if it decides that the public’s interest in the public inquiry or the information to be disclosed in the public inquiry is outweighed by the need to prevent the disclosure of information that could reasonably be expected to be injurious to,

(a) the administration of justice...

12. This provision is intended to provide a commission with the tools necessary to enable it to more effectively conduct its hearing process. The context within which it appears makes that clear:

Protection of confidential information

**10. (4)** A commission may impose conditions on the disclosure of information at a public inquiry to protect the confidentiality of that information.

Hearings

Holding a hearing

**14. (1)** A commission shall hold a **hearing** during the public inquiry only if authorized in the order establishing the commission.

Hearings open to the public

**(2)** Subject to subsection (3), a commission that is conducting a **hearing** shall,

- (a) give reasonable advance notice to the public of the schedule and location of the **hearing**;
- (b) ensure that the **hearing** is open to the public, either in person or by electronic means; and
- (c) give the public access to the information collected or received in the **hearing**.

Exclusion of public

**(3)** A commission may exclude the public from all or part of a **hearing** or take other measures to prevent the disclosure of information if it decides that the

<sup>2</sup> *Supra*.

<sup>3</sup> *Supra*.

<sup>4</sup> *Supra*.



public's interest in the public inquiry or the information to be disclosed in the public inquiry is outweighed by the need to prevent the disclosure of information that could reasonably be expected to be injurious to,

- (a) the administration of justice;
- (b) law enforcement;
- (c) national security; or
- (d) a person's privacy, security or financial interest.

Limitations on examinations

(4) A commission may reasonably limit examination and cross-examination of a witness where the commission is satisfied that it has been sufficient to disclose fully and fairly the facts in relation to which the witness has given evidence. [Emphasis added]

13. The conclusion that the authority given to me by these provisions of the statute were intended to allow me to effectively and efficiently control the hearing process does not mean, however, that those powers do not include the powers to order redaction of the report or a publication ban. Cory J., writing on behalf of himself, Iacobucci and Major JJ. in *Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy)*,<sup>5</sup> would have concluded that much sparser statutory language gave such powers to a commissioner appointed under the *Public Inquiries Act* of Nova Scotia. That statute provided:

The commissioner or commissioners shall have the same power to enforce the attendance of persons as witnesses and to compel them to give evidence and produce documents and things as is vested in the Supreme Court or a judge thereof in civil cases, and the same privileges and immunities as a judge of the Supreme Court.<sup>6</sup>

14. Justice Cory wrote:

In my view, the nature and the purpose of public inquiries require courts to give a generous interpretation to a commissioner's powers to control their own proceedings under the Nova Scotia Act. One of the functions of an inquiry is to insulate an investigation from both the legislative and the judicial branches of government. It is crucial that an inquiry both be and appear to be independent and impartial in order to satisfy the public desire to learn the truth. It is the commissioner who must be responsible for ensuring that the hearings are as public as possible yet still maintain the essential rights of the individual witnesses.

... It must be remembered that publicity bans, in camera hearings and other protective measures are exceptional remedies which will rarely be ordered on the basis of a prospective breach of s. 11(d). In an inquiry it is the commissioner who should first determine whether such exceptional orders should be issued.

**The authority to make those orders derives from and relates to the conduct of the inquiry hearings.** This authority should be given a reasonable and purposeful interpretation in order to provide commissions of inquiry with the

<sup>5</sup> [1995] 2 S.C.R. 97 ["Phillips"].

<sup>6</sup> *Public Inquiries Act*, R.S.N.S. 1989, c. 372, s. 5

ability to achieve their goals. It is appropriate that the Commissioner should be the first body to determine whether any of the exceptional orders concerning publicity bans or in camera hearings should be made.<sup>7</sup> [Emphasis added]

15. In my view, applying a similar generous and purposeful interpretation to a commissioner's powers under the *Public Inquiries Act, 2009* leads to the same conclusion. The powers to control the hearings include the power to grant the remedies sought by Mr. Wood.

16. In any event, however, it is apparent to me that Order in Council 1097/2012 creating the Commission makes it clear that I have such jurisdiction. It states:

3. The Commission shall perform its duties without expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization. **The Commission shall further ensure that the conduct of the inquiry does not in any way interfere or conflict with any ongoing investigation or proceeding related to these matters.** [Emphasis added]

17. Clearly, the production and delivery of my Report forms an integral part of the conduct of the Inquiry. While Mr. Wood's evidence is a matter of record, my findings, opinions and conclusions regarding his conduct might well, depending on their nature, be deemed, in some circumstances, sufficiently prejudicial that they could influence a jury's deliberations if published prior to trial.

18. I am directed by the Order in Council to ensure non-interference with a proceeding related to the matters in issue. Without doubt, Mr. Wood's impending criminal trial is such a proceeding. Redaction, if warranted, is the only realistic manner in which non-interference can be assured. I agree with counsel for Mr. Wood that a non-publication order, in the internet era, would not achieve the desired result. In this regard, Durno J. in *R. v. CTV*<sup>8</sup> commented:

In the global electronic age, placing meaningful restrictions on the flow of information is becoming increasingly difficult, substantially diminishing the actual effect of the bans. Dagenais, at para. 89. As Sproat J. held in *R. v. Y. (N.)*, [2008] O.J. No. 1217 (Ont. S.C.J.), at para. 51, "The starting point, therefore, is that in 2008 no publication ban is likely to be completely effective." In 2013-14, the challenges posed from the global electronic age are even more pronounced than in 2008. How effective a ban would be is a relevant consideration in determining whether to impose a ban. Dagenais, at para. 90. However, while it is possible that a ban will have no influence on trial fairness, such a case would be rare. Dagenais, at para. 91.

19. Once the Commission report has been delivered to the Attorney General, it is out of my control. I do not have the authority to order the Attorney General to redact portions of it.

<sup>7</sup> Phillips, *supra* at paras. 175-6.

<sup>8</sup> *R. v. CTV*, 2013 ONSC 5779, at para. 32.

20. In my view, s. 3 of Order in Council 1097/2012 gives me the authority to redact my Report prior to delivery, in the appropriate context and circumstances.

21. Furthermore, I agree with the Province's submission and with both L'Heureux-Dubé and Cory JJ. in *Phillips*<sup>9</sup> that the Commission is best placed to assess the potential harmful effects of evidence introduced at an Inquiry and the judicial use by a Commissioner of flexible measures to overcome individual threats to fair trial rights. Further, it is appropriate that the Commission be the first body to determine whether exceptional orders concerning publication bans or other measures should be made.

22. I now turn to whether or not the Orders sought by Mr. Wood should be issued.

### **C. Whether the Order sought by Mr. Wood should be granted**

#### **1. General Principles – Publication Ban**

23. Mr. Wood's request implicates the open court principle, and, hence, as was recognized by the Ontario Court of Appeal, must be approached with great care.<sup>10</sup>

24. The open court principle takes on particular importance in the context of a public inquiry, which has, as its purpose, the education of the public about the events leading up to a tragedy or worrisome community problem.<sup>11</sup>

25. It is well established that an order imposing restrictions on the open court principle should only be made when:

- a. such an order is necessary to prevent a serious risk to the proper administration of justice because reasonably alternative measures will not prevent the risk; and
- b. the salutary effects of the publication ban outweigh the deleterious effects on the rights and interests of the parties and the public, including the effects on the right to free expression, the right of the accused to a fair and public trial, and the efficacy of the administration of justice.<sup>12</sup>

26. The onus lies on the applicant to meet the two-part test, referred to as the *Dagenais/Mentuck* test.

27. The first prong of the test engages three factors: (1) the risk to the right to a fair trial; (2) the availability of alternative measures; and (3) the effectiveness of the publication ban.<sup>13</sup>

<sup>9</sup> *Phillips*, *supra*, at paras. 170, 175-6. See also reasons from L'Heureux-Dubé J. at paras. 36 and 38.

<sup>10</sup> *Pattison Outdoor Advertising LP v. Toronto (City)*, 2012 ONCA 212, at paras. 51.

<sup>11</sup> *Episcopal Corp. of the Diocese of Alexandra-Cornwall v. Cornwall (Public Inquiry)*, 2007 ONCA 20, at para. 48; *Phillips*, *supra* at paras. 36 and 62.

<sup>12</sup> See e.g. *R. v. Mentuck*, 2001 SCC 76, at para. 32 (commonly referred to as the *Dagenais/Mentuck* test).

<sup>13</sup> See *R. v. J.S.R.* [2008] O.J. NO. 4160, at paras. 30-33 (S.C.J.).



28. With respect to the first factor, the Supreme Court of Canada has held that the risk must be “real, substantial and well-grounded in the evidence.” An order restricting the open-court principle is not justified where there may be just some risk of prejudice to the fair trial rights of an accused or where the asserted risks to a fair trial are merely speculative.<sup>14</sup> In this regard, in *R. v. J.S.R.*, Nordheimer J. noted:

...I accept that there is a distinct possibility, if not a certainty, that there will be extensive media coverage of the trial of J.S-R. The mere fact of publicity, however, does not lead inexorably to the conclusion that the fair trial rights of accused persons, who are to be subsequently tried, will be impaired as a consequence. To some degree whether any impairment might occur will depend on the nature of the publicity, the extent of the publicity, the duration of the publicity and the likelihood of potential jurors recollecting that publicity and the degree of detail that any such recollection would involve.<sup>15</sup>

29. As concerns the second factor, “the publication ban must be the only remedy that will be able to achieve the prevention of that real and substantial risk to trial fairness. It must arise from the companion conclusion that reasonably available alternative measures will fail to prevent that risk.”<sup>16</sup>
30. Finally, it must be proven that the publication ban will be effective at preventing the risk to trial fairness.<sup>17</sup>

## 2. Publication ban in context of public inquiries

31. As noted above, I have not been referred to a single case where a court has considered or granted the type of order being sought in the present Application. The one case where a somewhat similar issue arose was in *Phillips*. The Court was asked to determine whether the evidentiary hearings of a commission of inquiry should be stayed until the completion of related criminal proceedings, whether the accused persons were compellable witnesses at the inquiry, and whether the Report of the commission should be held back from public release until after all criminal charges had been dealt with when the accused persons had elected trial by jury. The issues were eventually found to be moot and the majority of the Supreme Court of Canada declined to deal with them, the accused having re-elected to be tried by judge alone. Nonetheless, Cory and L’Heureux-Dubé JJ. chose to deal with the issues in *obiter*. While not binding, their comments are persuasive and informative.

32. Cory J. made the following statements:

124. ... A potential juror watching parts of televised hearings may not be unduly influenced by the testimony of any particular witness or witnesses. Common sense, however, suggests that the potential for lasting impartiality is

<sup>14</sup> *R v. Mentuck*, *supra* at para. 34. See also *R. v. J.S.R.*, *supra* at para. 30; *Canadian Broadcasting Corp. v. Canada*, 2013 ONSC 7309, at para. 30.

<sup>15</sup> *R. v. J.S.R.*, *supra* at para. 34.

<sup>16</sup> *R. v. J.S.R.*, *supra* at para. 31.

<sup>17</sup> *R. v. J.S.R.*, *supra* at para. 32.

much less when what is published are the carefully reasoned conclusions of a judge who has heard all the testimony and examined all of the evidence relevant to the inquiry mandate. The publication of these findings of facts and conclusions will create a much greater risk of prejudice to fair trial rights. It is this distinction which may require a different treatment of evidence presented in a public hearing and the final inquiry report. Thus, for example, the publication of the final report of the Hughes Inquiry was delayed until the completion of the trials of all the former brothers of Mount Cashel.

125. Some of the ideas expressed recently in *Dagenais v. Canadian Broadcasting Corp.*, supra, concerning the nature of the risks posed by pre-trial publicity to the fair trial rights of individual accused should be repeated. The influence which publicity will have upon jurors must be assessed in light of the circumstances presented by each case.

...

128. ... What must be found in order for relief to be granted is that there is a **high probability that the effect of publicizing inquiry hearings will be to leave potential jurors so irreparably prejudiced or to so impair the presumption of innocence that a fair trial is impossible.** Such a conclusion does not necessarily follow upon proof that there has been or will be a great deal of publicity given to the hearings. Evidence establishing the probable effects of the publicity is also required.

129. It is for this reason that I must respectfully disagree with the suggestion made by the trial judge in [*R. v.*] *Kenny* [(1991), 92 Nfld. & P.E.I.R. 318], supra, at p. 351, that an accused enjoys a constitutional right to “be free from excessive adverse publicity while his or her trial is pending”. The right which the accused enjoys is the right to a fair trial. If excessive adverse pre-trial publicity will violate this right, then s. 24(1) of the Charter requires that judicial relief be given. But relief should only follow satisfactory proof of a link between the publicity and its adverse effects. Negative publicity does not, in itself, preclude a fair trial. The nexus between publicity and its lasting effects may not be susceptible of scientific proof, but the focus must be upon that link and not upon the mere existence of publicity.

130. Further, the examination of the effects of publicity cannot be undertaken in isolation. The alleged partiality of jurors can only be measured in the context of the highly developed system of safeguards which have evolved in order to prevent just such a problem. Only when these safeguards are inadequate to guarantee impartiality will s. 11(d) be breached. This simple determination requires the resolution of two difficult questions. First, what is an impartial juror? Second, when do the safeguards of the jury system prevent jury prejudice?

...

132. ... It comes down to this: in order to hold a fair trial it must be possible to find jurors who, although familiar with the case, are able to discard any previously formed opinions and to embark upon their duties armed with both an

assumption that the accused is innocent until proven otherwise, and a willingness to determine liability based solely on the evidence presented at trial.

133. I am of the view that **this objective is readily attainable in the vast majority of criminal trials even in the face of a great deal of publicity.** The jury system is a cornerstone of our democratic society. The presence of a jury has for centuries been the hallmark of a fair trial. I cannot accept the contention that increasing mass media attention to a particular case has made this vital institution either obsolete or unworkable. There is no doubt that extensive publicity can prompt discussion, speculation, and the formation of preliminary opinions in the minds of potential jurors. However, the strength of the jury has always been the faith accorded to the good will and good sense of the individual jurors in any given case. The confidence in the ability of jurors to accomplish their tasks has been put this way in *R. v. W. (D.)*, [1991] 1 S.C.R. 742, at p. 761:

Today's jurors are intelligent and conscientious, anxious to perform their duties as jurors in the best possible manner. They are not likely to be forgetful of instructions. ...

The danger of a miscarriage of justice clearly exists and must be taken into account but, on the other hand, I do not feel that, in deciding a question of this kind, one must proceed on the assumption that jurors are morons, completely devoid of intelligence and totally incapable of understanding a rule of evidence of this type or of acting in accordance with it. If such were the case there would be no justification at all for the existence of juries. ...

134. The solemnity of the juror's oath, the existence of procedures such as change of venue and challenge for cause, and the careful attention which jurors pay to the instructions of a judge all help to ensure that jurors will carry out their duties impartially. In rare cases, sufficient proof that these safeguards are not likely to prevent juror bias may warrant some form of relief being granted under s. 24(1) of the Charter. The relief may take many forms. It may be the enjoining of hearings at a public inquiry, a publication ban on some of the evidence given at the inquiry, a staying of the criminal charges, or the imposition of additional protections for the defence at the stage of jury selection ... . As this Court has held in the past, this type of relief will not be granted on the basis of speculation alone. Normally the time for assessing whether or not an accused's fair trial rights have been so impaired that s. 24(1) relief is required will be at the time of jury selection: *Vermette*, supra; *R. v. Sherratt*, [1991] 1 S.C.R. 509.

...

163. ... For the reasons set out earlier, I am of the view that the publication of the Commissioner's conclusions prior to the completion of the criminal trials could have very well influenced the jurors in their deliberations. The publication of the report should be delayed until such time as Parry and Phillips have had an opportunity to review it and, if so advised, to bring an application to ban its



publication until such time as the criminal charges had been disposed of after trial or stayed.<sup>18</sup> [Emphasis added]

33. L'Heureux-Dubé disagreed with Cory J. She wrote:

34...In my view, although an accused who is being tried before a judge and jury may be prejudiced by pre-trial publicity related to a public inquiry, it is only in the most extraordinary of circumstances that a stay of a public inquiry's proceedings should be issued to remedy such a potential violation of s. 11(d) of the Charter. This is for two reasons. First, the risk of prejudice to an accused's fair trial rights from pre-trial publicity is highly speculative. Consequently, it will be extremely difficult to prove such a prospective violation of s. 11(d) of the Charter with a sufficient degree of probability to warrant the granting of a remedy. Second, even if the potential violation of s. 11(d) is shown to be sufficiently likely to warrant a remedy, a stay of proceedings would not generally be the appropriate remedy.

40. Before concluding, I feel it is necessary to comment briefly on an obiter statement of Cory J.'s with which I disagree. Specifically, in his reasons, Cory J. suggests that, had Roger Parry and Gerald Phillips not changed their election to be tried before a judge and jury, it would have been appropriate to order that the publication and release of the Commissioner's final report be delayed so as to provide them with an opportunity to review it and, if they deemed it necessary, to bring an application to ban its publication until such time as the criminal proceedings against them were completed or disposed of in some other manner. In my view, however, the imposition of such a temporary publication ban would not have been appropriate. **First, for a publication ban, even a temporary one such as the one suggested by Cory J. to be imposed, the risk of prejudice to the fair trial rights of an accused must be serious and not overly speculative. In the hypothetical situation proposed by Cory J., however, the risk of prejudice to the fair trial rights of the respondents in question would have been, in my opinion, based far too heavily on speculation.**<sup>19</sup> [Emphasis added]

34. Besides being released prior to *Mentuck* and other Supreme Court decisions on publication bans, it should be noted that in *Phillips* no evidence had yet been heard by the commission of inquiry with which that case was concerned. In my view, the above *obiter dicta* comments from Cory J. and L'Heureux-Dubé J. must be considered through the lens of the more recent jurisprudence on publication bans and more recent judicial comments on trials by jury.

### 3. Mr. Wood's Application does not meet the *Dagenais/Mentuck* test

35. I now turn to the relevant facts in issue.

<sup>18</sup> *Phillips*, *supra* at paras. 124-125, 128-130, 132-134 and 163.

<sup>19</sup> *Phillips*, *supra* at para. 40.

36. Mr. Wood was a structural engineer who authored, among other things, a report in May 2012 regarding the structural soundness of the Algo Centre Mall shortly before its collapse. Given his role, Mr. Wood was granted standing in Part I of the Inquiry.

37. On April 22, 2013, as the hearings were ongoing, Mr. Wood was charged with endangering a worker as a result of providing negligent advice, and working in a manner that may endanger a worker, pursuant to s. 31(2) and 28(2)(b) of the *Occupational Health and Safety Act*. These charges arose from the events being investigated by this Commission. The following day, counsel for Mr. Wood advised the Commission of the following:

On yesterday's date Mr. Wood was charged under the Occupational Health and Safety Act with a charge... I wanted to reassure the Commission that I have spoken to my client, Mr. Wood, and he remains committed to participating in the Commission, understanding very clearly that the purpose of the Commission is not to assign fault... But I wanted to publically state on behalf of Mr. Wood that he does remain committed. He's going to be attending to provide information with respect to his willsay statement, and he'll also be attending to give evidence. And the purpose of that participation is to assist the Commission.<sup>20</sup>

38. On June 6 and 7, after collaborating with Commission Counsel by attending an interview and preparing a will-say statement, Mr. Wood testified before the Inquiry.

39. Following his testimony, Mr. Wood was served with a confidential notice pursuant to s. 17 of the *Public Inquiries Act, 2009*,<sup>21</sup> providing him with notice that the Commission may make a finding of misconduct against him (a confidential fact disclosed by Mr. Wood in his Application).

40. On January 31, 2014, well after the conclusion of the Commission's hearings, Mr. Wood was charged with two counts of criminal negligence causing death and one count of criminal negligence causing bodily harm pursuant to s. 220(b) and 221 of the *Criminal Code*. Counsel for Mr. Wood readily admitted that at the time he made submissions to the Commission with respect to Mr. Wood's involvement with the Algo Mall, he was aware a criminal investigation was underway. Mr. Wood had been interviewed by the OPP and had reviewed (along with his counsel) certain warrants and informations to obtain.<sup>22</sup>

41. It is well established that there can be no justification for a publication ban premised on the need to avoid a breach of the fair trial rights guaranteed by s. 11(d) of the *Charter* unless the accused person has elected to be tried by a judge and jury.<sup>23</sup>

42. Pursuant to s. 536(2) of the *Criminal Code*, Mr. Wood has the option of electing to be tried by a judge of the Ontario Court of Justice, by a judge of the Superior Court of Justice without a jury, or by a judge of the Superior Court of Justice with a jury. Mr. Wood has not yet made

<sup>20</sup> Transcript, April 23, 2013, pp. 6311-2.

<sup>21</sup> *Supra*

<sup>22</sup> Transcript, June 20, 2014, p. 14.

<sup>23</sup> *Phillips, supra* at paras. 4, 32 and 139.

his election. Obviously, his preliminary hearing has yet to be scheduled. When and if it does come to be scheduled, it would not likely be until 2015.

43. I agree with the Media Organizations that Mr. Wood's Application by its very nature is speculative. Because he has not made his election, it is not known whether he will be tried by a court composed of a judge and a jury. Considering the nature of the charges, I do not think it was an unfair statement on the part of counsel for the Media Organizations to characterize this possible election of a trial by jury as a "big 'If'".<sup>24</sup> Nonetheless, Mr. Wood is entitled, if he does make this election, to have a fair trial.
44. Furthermore, it is not known when Mr. Wood's criminal trial can be expected to take place. I do not think it is unreasonable to assume that, given that there has been limited Crown disclosure, Mr. Wood's trial (assuming he is committed) is unlikely to take place, in the best of scenarios, until late 2015.
45. The Commission, on the other hand, must deliver its final report to the Attorney General by no later than October 31, 2014 (a deadline I intend to meet). I expect that, as has been the long-standing practice, discussions will take place between officials of the Ministry of the Attorney General and the Commission with respect to the process for the public release of the Report.

**a. The Order sought is not necessary to prevent a serious risk**

46. The nature of Mr. Wood's Application is inherently problematic, despite its apparent simplicity. Were I to grant it, redaction could not be limited to a mere blanking out of Mr. Wood's name. The depth of the redaction, to be truly protective, would of necessity be extensive, as conclusions are traced back to their original premise. Findings could not be left dangling, lest their source be easily guessed. This is doubly difficult when complex and intermingled causes lead to compendious conclusions.
47. But even despite that editorial difficulty, I am of the view that Mr. Woods fails to meet the first component of the *Dagenais/Mentuck* test. In my view, he has failed to show that the orders sought are necessary to prevent serious risk to the proper administration of justice, that no alternative measures may prevent such a risk and that such an order would be effective.
48. Mr. Wood claims that the evidence of risk lies in the fact that the Commission will be delivering a final Report which may include findings of fact that may impact Mr. Wood.<sup>25</sup> Counsel for Mr. Wood explained:

...one of the crucial elements of a fair trial is the right to be tried solely on the evidence before the Court, and not on any information received outside that context. And I quote that specific passage in that, in my respectful submission, because there has been so much evidence before this Commission, and so much of the evidence has been cross-examined on, and published, that evidence will

<sup>24</sup> Transcript, June 20, p. 51.

<sup>25</sup> Transcript, June 20, 2014, pp. 11-12.



be understood, I submit, by the public, as the underpinning for the findings of fact that this Commission will make. Therefore, by extension, the **possibility** that finding based upon that evidence, which as I've indicated earlier in my submissions, is much far-reaching than what may be available at the criminal trial, there will be a finding of additional evidence and evidence that a potential juror **may** rely upon while serving their role as a juror at this trial.

Again, that's **speculation** but the laws prevent any correspondence or communication with jurors once they've completed their duties...<sup>26</sup> [Emphasis added]

49. At the risk of repeating myself, let me emphasize that commissions of inquiry, by their very nature, will investigate matters which are of significant public importance and will attract public interest. The simple fact of the existence of this Commission cannot be sufficient to meet the necessity test in *Dagenais/Mentuck*.

50. Mr. Wood's Application is effectively founded on the purported risk that the release of the Commission's report would irremediably taint the pool of potential jurors in his criminal trial. It is apparent from the recent case law that courts have been affording less weight to this concern given the lack of evidence to suggest that it is impossible to empanel an impartial jury.

51. The particular issue of whether pre-trial publicity will prejudice an accused's fair trial rights by placing "irreversible ideas" regarding the actions of the accused in the minds of potential jurors was canvassed by Nordheimer J. in his decision authorizing the release of informations to obtain in the investigation that led to extortion charges being laid against Alexander Lisi (relating to the video of the Mayor of Toronto allegedly smoking crack cocaine).<sup>27</sup> As part of his analysis of the risk to Mr. Lisi's fair trial rights, Nordheimer J. considered four factors, which find application in the present case, namely: (1) the pre-existing publicity on the same matter (2) the effect of the passage of time before a trial will actually commence; (3) the effect of jury instructions; and (4) the challenge for cause process.

52. On the pre-existing publicity, Nordheimer J. noted:

I am prepared to accept that there is some risk to Mr. Lisi's fair trial rights that might arise from the release of this material. Undoubtedly some of the references in the intercepted private communications will not reflect well on Mr. Lisi. But I contrast that possibility with certain other salient facts. **One is that there has already been a fair amount of publicity in this matter that does not reflect well on Mr. Lisi, as his counsel fairly acknowledged. It is not therefore clear that this additional material will significantly affect any impressions that may have already formed in the minds of the public.**<sup>28</sup> [Emphasis added]

<sup>26</sup> Transcript, June 20, 2014, pp. 15-16.

<sup>27</sup> *Canadian Broadcasting Corp. v. Canada*, *supra* at para. 37.

<sup>28</sup> *Canadian Broadcasting Corp. v. Canada*, *supra* at para. 40. See also *Toronto Star Newspapers Ltd. v. Ontario*, 2014 ONSC 2131, at paras. 10 and 13.

53. In the present case, Mr. Wood testified over two days in June 2013 in a hearing that was open to the public, broadcast live and reported on by the press. Other witnesses also testified and gave evidence in respect of Mr. Wood's actions. Many Participants filed submissions urging me to make certain findings with respect to Mr. Wood's conduct. The evidence and those submissions are all available on the Commission's website.
54. I note parenthetically that notice of the present Application was only given to the Commission on April 25, 2014, almost three months after Mr. Wood was charged under the *Criminal Code*, and when I was fully engaged in drafting the Report.
55. Further, as acknowledged by Mr. Wood, the Commission has to date attracted a fair amount of publicity, some of which was directed at Mr. Wood. Indeed, Mr. Wood has also already been the subject of extensive media reports discussing his role in the events that led to the collapse of the Mall, including the inspection he conducted in May 2012, mere weeks prior to the collapse.
56. Notwithstanding this pre-existing publicity, Mr. Wood claims that the Commission's report is of a different ilk than that of a media report as additional consideration will be afforded to the commissioner's findings and opinions by the public. While this may be the case, I first wish to note that the Order in Council prohibits me from making any findings with regard to the potential civil or criminal liability of any person. But more importantly, Mr. Wood's position fails to take into account the realities surrounding the jury selection and instruction processes as well as the right to seek a change of venue.
57. In this regard, in *Canadian Broadcasting Corp. v. Canada*, after observing that the jury trial would not likely take place until two or three years in the future, Nordheimer J. wrote:

**Another consideration is the effect that the passage of time can have. Despite what some may think, experience shows that members of the public do not remember, in any great detail, events that they read or heard about months earlier.** Anyone with experience sitting through a challenge for cause based on publicity can attest to that reality. People either paid little or no attention to the matter in the first instance, or have only the vaguest recollections of the event when questioned about it through the challenge process...<sup>29</sup> [Emphasis added]

58. The same applies in the present case. As I noted above, Mr. Wood's trial is not likely to occur before late 2015, at least one year after the release of this Commission's Report, by which time memories of potential jurors will undoubtedly have faded. On the other hand, is it reasonable to keep an integral and significant part of the Commission's report hidden all this time? I think not.
59. Moreover, Mr. Wood will not be the sole focus of the Commission's Report. After all, this is not an inquiry into Mr. Wood's conduct. Throughout the hearings, the Commission investigated the actions and conducts of many persons, corporations and governments

<sup>29</sup> *Canadian Broadcasting Corp. v. Canada*, *supra* at para. 41. See also *Toronto Star Newspapers Ltd. v. Ontario*, *supra* at para. 11.

(dealing both with the collapse of the Mall and the emergency response), all of which I am analyzing for the purpose of my Report and which, it is safe to assume, will form part of it. During the Part I hearings, I was concerned with a constellation of events and actions occurring over a span of many years that may have led to the Mall's demise and its collapse.

60. Furthermore, redacting the Report of the findings and conclusions relating to Mr. Wood's actions or credibility could have an unintended opposite effect. Large or multiple sections of redacted material could lead the public to speculate on the conclusions made in the Report about Mr. Wood. That speculation may lead to exaggerated notions about imaginary negative conclusions, not borne out by the Commission's eventual findings. The identity of the person whose conduct is the subject of redaction will not be difficult to discern. The unintended consequence of editing could be more damaging than publication.
61. In my view, Mr. Wood has failed to demonstrate a real, substantial and well-grounded risk.
62. Turning to available alternative measures that would prevent the risk to a fair trial, I agree with the Media Organizations that one should not assume that persons summoned for jury duty will not be able to disassociate themselves from information that they may have heard or read in the media.<sup>30</sup> The whole jury system depends on jurors acting responsibly and in good faith and obeying the direction of the trial judge. Nonetheless, safeguards are available to ensure that any risks are eliminated, including jury instructions, challenge for cause and change of venue.
63. In *Toronto Star Newspapers Ltd. v. Ontario*, a subsequent application for access to informations to obtain related to the charges against Mr. Lisi, Nordheimer J. commented on some of these safeguards:

In terms of the effectiveness of jury instructions, I accept that they are not a panacea for all harm to fair trial rights. There are limits to what jury instructions can accomplish. This limitation was noted in *Dagenais*, where Lamer C.J.C. said, at p. 886 S.C.R.:

More problematic is the situation in which there is a period of sustained pre-trial publicity concerning matters that will be the subject of the trial. In such circumstances, the effect of instructions is considerably lessened. Impressions may be created in the minds of the jury that cannot be consciously dispelled. The jury may at the end of the day be unable to separate the evidence in court from information that was implanted by a steady stream of publicity.

In assessing whether the release of these intercepted communications would materially add to any impressions that may be created in the minds of the jurors, it is relevant to consider that there has already been a fair amount of publicity surrounding this matter. The public knows about Mr. Lisi's earlier activities and they know he has been charged with extortion. The public also knows why Mr. Lisi is charged with extortion. ...

<sup>30</sup> *Canadian Broadcasting Corp. v. Canada*, *supra* at para. 50.



...

Finally, there is the challenge for cause process. I note that the challenge for cause process, while mentioned in Dagenais, was not the subject of any real discussion in the reasons in terms of available alternative measures. Yet it is, in my view, a very important alternative measure. A challenge for cause based on pre-trial publicity is directed at revealing the very concern that Mr. Lisi raises here. **It is designed to identify those prospective jurors who have been exposed to such publicity and who cannot fairly judge the accused person as a consequence. It is that latter factor that is the key one. It is not simply that a prospective juror has been exposed to pre-trial publicity. It is whether that exposure has caused the prospective juror to no longer be impartial that is critical.** ...

Each prospective juror must proceed through what is, in essence, three levels of review. The first level of review is the prospective juror's answers to the challenge questions. If they have formed opinions about the case based on what they have read, seen, or heard about it, we expect the prospective juror to say so. ...

The second level of review is by the triers. Each prospective juror's answers are subject to evaluation by two other citizens who have been sworn as triers. The triers are tasked with evaluating the prospective juror's answers with a view to determining whether the ability of any prospective juror to decide the case based solely on the evidence will be affected by what s/he has read, seen or heard about it.

The third level of review is each side's right to challenge prospective jurors peremptorily. ...

The challenge for cause process represents an important screening tool to ensure that pre-trial publicity has not left jurors with irreversible impressions. I accept that it is possible that a prospective juror could mask their true state of mind and thus survive the challenge for cause process. I do not believe, however, that we can approach the analysis of reasonable alternative measures on that negative footing. Rather, we must approach the analysis on the assumption that persons involved in the process will conduct themselves honestly and in the spirit that we expect of our fellow citizens.

Consequently, it would, in my view, require the publication of especially egregious material to conclude that a publication ban is "necessary" to ensure an accused person's right to a fair trial in light of the alternative measures that are available.<sup>31</sup> [Emphasis added]

64. While there may be limits on the effectiveness of jury instructions, in my view, the pre-existing publicity surrounding Mr. Wood's actions, the length of time before he is to be tried and the fact that Mr. Wood's conduct will only constitute a narrow portion of the

<sup>31</sup> *Toronto Star Newspapers Ltd. v. Ontario*, *supra* at paras. 12-20.

Commission’s report, lead me to conclude that the challenge for cause process would effectively insulate him from potential jury tainting.

65. In support of his Application, Mr. Wood also suggests that there may be evidence introduced during the Commission hearings, relied upon to make my findings, that may not be admissible at his trial. In the recent decision of Durno J. in *R. v. CTV*<sup>32</sup>, this was an important factor which led to the Court refusing to unseal portions of informations to obtain search warrants, general warrants and a production order. I do not believe the same concern applies here.
66. First, it is important to reiterate that all the evidence that was introduced before the Commission was broadcast and has been (and remains) available for public viewing on the Commission website. But, more importantly, in addition to the realities I discuss above, additional safeguards are afforded to Mr. Wood by the *Public Inquiries Act, 2009*,<sup>33</sup> the *Charter*<sup>34</sup> and the *Canada Evidence Act*<sup>35</sup> relating to the admissibility at his criminal trial of any incriminating statements he may have made during the Inquiry.
67. There is, of course, a fundamental difference between the unproven allegations contained in an information to obtain a court authorization and the findings of a commission. While a commission is not bound by the strict rules of evidence, its findings will be reasoned, principled and based on evidence that has been scrutinized in a fair and open process with participant representation and oversight.
68. Mr. Wood in his Application also attempts to diminish the impact of his request by claiming that it is a “temporary limited exercise.”<sup>36</sup> I disagree. The redaction order is one that could be in effect for a significant period of time before Mr. Wood’s trial is held. Any attempt to characterize such an order as temporary would be, in Nordheimer J.’s words, to “ignore the reality”:

The impact of a publication ban of that length on the immediacy that naturally arises from the public’s right to have information, especially when it relates to current affairs, is so significant that it may well be, in practical terms, the equivalent of a permanent ban.<sup>37</sup>

69. Furthermore, such a redaction order would prevent the publication of a possibly important and integral part of the Report, which the public and the community of Elliot Lake have been waiting for for over two years. Indeed, the result could be that part of my findings and recommendations would appear insufficiently substantiated or advanced without a fulsome analysis. I adopt in this regard the following submissions of counsel for the Media Organizations:

<sup>32</sup> *R. v. CTV*, *supra* at paras. 107-122.

<sup>33</sup> *Public Inquiries Act, 2009*, *supra*, s. 16.

<sup>34</sup> *Canadian Charter of Rights and Freedoms*, s. 13.

<sup>35</sup> *Canada Evidence Act*, R.S.C. 1985, c. E-10, s. 5.

<sup>36</sup> Factum of Mr. Wood, dated May 30, 2014, at para. 76.

<sup>37</sup> *Canadian Broadcasting Corp. v. Canada*, *supra* at para. 55.

The public needs to know and the public does not get to know by knowing only parts of the report, by only getting access to parts of the report, or only getting – getting it piecemeal. We know how matters are received by the public. They are not going to read – be able to read, in context, the report a year and a half or two years from now after the criminal proceeding is finished. They are not going to take your redacted report and be able to read sense into it a year and a half later.<sup>38</sup>

70. Mr. Wood had to show that the publication of the Commission's report would pose a serious threat (grounded in evidence) to the proper administration of justice through a risk to his fair trial rights. In light of the alternative methods available to address any concerns regarding the impact the publication of the Report may have on potential jurors, I am not convinced that the Report will impair Mr. Wood's rights under s. 11(d) of the *Charter* and I therefore conclude that he has failed to discharge this heavy onus.

**b. The balance favours the freedom of expression**

71. Having concluded that Mr. Wood failed to prove that it is necessary for me to order the redaction of my Report, there is no need for me to deal with the second prong of the *Dagenais/Mentuck* test.
72. Nevertheless, one deleterious effect I am bound to mention involves the costs associated with a redaction. Re-publication of the unredacted Report after trial (or after an election other than judge and jury or other eventuality) would involve significant additional costs to be borne by the public purse. While this is clearly not the most important factor to be considered in the weighing process, it deserves mention.
73. I conclude by emphasizing the particular role that commissions of inquiry play in the public forum, which would be considered in this balancing exercise between the salutary effects and deleterious effects of the order sought:

One of the primary functions of public inquiries is fact-finding. They are often convened, in the wake of public shock, horror, disillusionment, or scepticism, in order to uncover "the truth". Inquiries are, like the judiciary, independent; unlike the judiciary, they are often endowed with wide-ranging investigative powers. In following their mandates, commissions of inquiry are, ideally, free from partisan loyalties and better able than Parliament or the legislatures to take a long term view of the problem presented. Cynics decry public inquiries as a means used by the government to postpone acting in circumstances which often call for speedy action. Yet, these inquiries can and do fulfil an important function in Canadian society. In times of public questioning, stress and concern they provide the means for Canadians to be apprised of the conditions pertaining to a worrisome community problem and to be a part of the recommendations that are aimed at resolving the problem. Both the status and high public respect for the commissioner and the open and public nature of the

<sup>38</sup> Transcript, June 20, 2014, p. 49.



hearing help to restore public confidence not only in the institution or situation investigated but also in the process of government as a whole. They are an excellent means of informing and educating concerned members of the public.<sup>39</sup>

74. For these reasons, I dismiss Mr. Wood's Application.

ISSUED at Ottawa, Ontario, this 28<sup>th</sup> day of July, 2014.

\_\_\_\_\_  
The Honourable Paul R. Bélanger,  
Commissioner

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<sup>39</sup> *Phillips, supra* at para. 62.

## Appendix N – Example of summons

**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger  
Commissioner



**LA COMMISSION D'ENQUETE  
ELLIOT LAKE**

L'honorable Paul R. Bélanger Commissaire

November, 2012

Dear \_\_\_\_\_,

**Re: Elliot Lake Commission of Inquiry**

I am writing to you in your capacity as \_\_\_\_\_

The Commission wants to ensure that it is being seen as treating all those who are affected by its proceedings in a way which is fair and equitable. Furthermore, it is required by the Order in Council which created it to operate under very strict timelines. Consequently, it has been decided that the Commission will issue a summons to every person from whom it is seeking documents or information. At an appropriate time, the individual to whom each summons is directed will be asked to certify in writing that all the appropriate searches have been conducted and the required documents have been produced.

I enclose herewith the Summons directed to you by Commissioner Bélanger. *I would appreciate it if you could advise me whether you are prepared to accept service of this Summons.* An e-mail to this effect would suffice. This would avoid the necessity to arrange personal service.

Where available, the Commission requires that documents in electronic format be received in that format (for example, MS Outlook allows users to put eMails in a folder and export to a PST file). PSTs, Word, Excel, PowerPoint, Adobe (PDF), HTML (emails), etc. can be copied to an external media such as a CD, DVD, USB Key, Hard Drive, etc. and sent to the Commission for processing. Our technician can assist with this if necessary.

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Ottawa, Ontario K1J 9B8

info@elliottlakeinquiry.ca

1400, Place Blair, 6<sup>e</sup> étage  
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**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger,  
Commissioner

**LA COMMISSION  
D'ENQUETE ELLIOT LAKE**

L'honorable Paul R. Bélanger,  
Commissaire

If you wish to discuss this Summons, or any issue relating to the Commission of Inquiry,  
please feel free to contact me at the following coordinates:

I look forward to working with you over the course of this Inquiry.

Yours very truly,

Commission Counsel

Encl.

1400 Blair Place, 6<sup>th</sup> Floor  
Ottawa, Ontario K1J 9B8

[info@elliottlakeinquiry.ca](mailto:info@elliottlakeinquiry.ca)

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**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger,  
Commissioner

**LA COMMISSION  
D'ENQUÊTE ELLIOT LAKE**

L'honorable Paul R. Bélanger,  
Commissaire

**SUMMONS TO PRODUCE DOCUMENTS**

(Section 10(1)(b), *Public Inquiries Act*, 2009)

**TO:**

You are hereby required to produce the following “documents”, which word includes any memorandum, note, data, analysis, report, minutes, briefing material, submission, correspondence, record, photograph, sound recording, videotape, film, chart, graph, map, plan, survey, book of account, or any other note or communication in writing, and data and information in electronic form, including material in off-site storage or which has been archived, including on microfiche, and specifically includes electronic communications including both internal e-mails and e-mails sent to or received from external sources, for the time period commencing \_\_\_\_\_, and continuing through the present and concluding at the conclusion of the public hearings of this Commission, in the possession, custody or control of you personally, your office, \_\_\_\_\_, including all predecessors, agents, outlets, servants or contractors, and present and former employees:

- a.
- b.
- c.

All documents and information are to be delivered by \_\_\_\_\_ electronically, to \_\_\_\_\_, and in hard copy to those individuals at the offices of the Inquiry, 99 Spine Road, Elliot Lake, ON.

ISSUED at Ottawa, Ontario, this \_\_\_\_\_ day of \_\_\_\_\_, 2014.

\_\_\_\_\_  
The Honourable Paul R. Bélanger,  
Commissioner

99 Spine Road, 2nd Floor  
Elliot Lake, Ontario P5A 3S9

info@elliottlakeinquiry.ca

99, rue Spine, 2e étage  
Elliot Lake, (Ontario) P5A 3S9

## Appendix O – Undertaking re confidentiality

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

#### APPENDIX "A"

### Confidentiality Undertaking for Counsel to Participants or Potential Witnesses in the Elliot Lake Commission of Inquiry

For the purpose of this Undertaking, the term "document" is intended to have a broad meaning, and includes any and all documents and information in connection with the proceedings of the Elliot Lake Commission of Inquiry (the "Inquiry" or "Commission"), including without limitation, any and all technical, corporate, financial, economic and legal information and documentation, financial projection and budgets, plans, reports, opinions, models, photographs, recordings, personal training materials, memoranda, notes, data, analysis, minutes, briefing materials, submissions, correspondence, records, sound recordings, videotapes, films, charts, graphs, maps, surveys, books of account, or any other notes or communications in writing, and data and information in electronic form, any data and information recorded or stored by means of any device and any other information pertaining to the Inquiry, irrespective of whether such information or documentation has been identified as confidential, and includes all other material prepared containing or based, in whole or in part, on any information included in the foregoing, including will-say statements referred to in Rule 45 above.

I, \_\_\_\_\_, undertake to the Elliot Lake Commission of Inquiry that any and all documents which are produced to me in connection with the Commission's proceedings will not be used by me for any purpose other than those proceedings. I further undertake that I will not disclose any such documents to anyone for whom I do not act or who has not been retained as an expert for the purposes of the Inquiry. In respect of anyone for whom I act, or any witness, or any expert retained for the purposes of the Inquiry, I further undertake that I will only disclose such documents upon the individual in question giving the written undertaking annexed as Appendix "B" to the *Rules of Procedures* (revised December 20, 2012).

I understand that this undertaking has no force or effect with respect to any document which has become part of the public proceedings of the Commission, or to the extent that the Commissioner has provided a written release to me from the undertaking with respect to any document. For

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Ottawa (Ontario) K1J 9B8

greater certainty, a document is only part of the public proceedings once the document is made an exhibit at the Inquiry.

With respect to those documents which remain subject to this undertaking at the end of the Inquiry, I undertake to either destroy those documents, and provide a certificate of destruction to the Commission, or to return those documents to the Commission for destruction. I further undertake to collect for destruction such documents from anyone to whom I have disclosed any documents which were produced to me in connection with the Commission's proceedings.

I understand that a breach of any of the provisions of this Undertaking is a breach of an order made by the Commission.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger,  
Commissioner



**LA COMMISSION  
D'ENQUÊTE ELLIOT LAKE**

L'honorable Paul R. Bélanger,  
Commissaire

**APPENDIX "B"**

**Confidentiality Undertaking  
for Participants and Potential Witnesses with Counsel to the  
Elliot Lake Commission of Inquiry**

For the purpose of this Undertaking, the term "document" is intended to have a broad meaning, and includes any and all documents and information in connection with the proceedings of the Elliot Lake Commission of Inquiry (the "Inquiry" or "Commission"), including without limitation, any and all technical, corporate, financial, economic and legal information and documentation, financial projection and budgets, plans, reports, opinions, models, photographs, recordings, personal training materials, memoranda, notes, data, analysis, minutes, briefing materials, submissions, correspondence, records, sound recordings, videotapes, films, charts, graphs, maps, surveys, books of account, or any other notes or communications in writing, and data and information in electronic form, any data and information recorded or stored by means of any device and any other information pertaining to the Inquiry, irrespective of whether such information or documentation has been identified as confidential, and includes all other material prepared containing or based, in whole or in part, on any information included in the foregoing, including will-say statements referred to in Rule 45 above.

I, \_\_\_\_\_, undertake to the Elliot Lake Commission of Inquiry that any and all documents which are produced to me in connection with the Commission's proceedings will not be used by me for any purpose other than those proceedings. I further undertake that I will not disclose any such documents to anyone.

I understand that this undertaking has no force or effect with respect to any document which has become part of the public proceedings of the Commission, or to the extent that the Commissioner

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has provided a written release to me from the undertaking with respect to any document. For greater certainty, a document is only part of the public proceedings once the document is made an exhibit at the Inquiry.

With respect to those documents which remain subject to this undertaking at the end of the Inquiry, I further understand that such documents will be collected from me by the person acting as my counsel who disclosed them to me.

I understand that a breach of any of the provisions of this Undertaking is a breach of an order made by the Commission.

\_\_\_\_\_  
Signature

Print Name: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Print Name: \_\_\_\_\_

\_\_\_\_\_  
Date

**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger,  
Commissioner



**LA COMMISSION  
D'ENQUETE ELLIOT LAKE**

L'honorable Paul R. Bélanger,  
Commissaire

**APPENDIX "C"**

**Confidentiality Undertaking  
for Potential Witnesses or Participants with No Counsel to  
the Elliot Lake Commission of Inquiry**

For the purpose of this Undertaking, the term "document" is intended to have a broad meaning, and includes any and all documents and information in connection with the proceedings of the Elliot Lake Commission of Inquiry (the "Inquiry" or "Commission"), including without limitation, any and all technical, corporate, financial, economic and legal information and documentation, financial projection and budgets, plans, reports, opinions, models, photographs, recordings, personal training materials, memoranda, notes, data, analysis, minutes, briefing materials, submissions, correspondence, records, sound recordings, videotapes, films, charts, graphs, maps, surveys, books of account, or any other notes or communications in writing, and data and information in electronic form, any data and information recorded or stored by means of any device and any other information pertaining to the Inquiry, irrespective of whether such information or documentation has been identified as confidential, and includes all other material prepared containing or based, in whole or in part, on any information included in the foregoing, including will-say statement referred to in Rule 45 above.

I, \_\_\_\_\_, undertake to the Elliot Lake Commission of Inquiry that any and all documents which are produced to me in connection with the Commission's proceedings will not be used by me for any purpose other than those proceedings. I further undertake that I will not disclose any such documents to anyone.

I understand that this undertaking has no force or effect with respect to any document which has become part of the public proceedings of the Commission, or to the extent that the Commissioner

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has provided a written release to me from the undertaking with respect to any document. For greater certainty, a document is only part of the public proceedings once the document is made an exhibit at the Inquiry.

With respect to those documents which remain subject to this undertaking at the end of the Inquiry, I further understand that such documents will be collected from me by Commission Counsel or a person designated by the Commission Counsel who disclosed them to me.

I understand that a breach of any of the provisions of this Undertaking is a breach of an order made by the Commission.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## Appendix P – Certificate of production

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

### Certificate of Production of Documents

I [full name], of the City of \_\_\_\_\_, in the Province of Ontario, (title) at (entity), have made the necessary enquiries of others to inform myself in order to make this Certification and, to the full extent of my knowledge, information and belief, based on those enquiries, do CERTIFY THAT:

1. (Name of entity or I, if individual) received a Summons from the Elliot Lake Commission of Inquiry dated (date) , a copy of which is attached as Appendix "A" (the "Summons");
2. In accordance with the Summons and correspondence from the Commission dated \_\_\_\_\_, the search for documents included all documents, as defined in the Summons, for the period commencing January 1, 1978 and continuing through the present in relation to the \_\_\_\_\_ categories of documents outlined in the Summons.
3. Staff and employees of \_\_\_\_\_ were directed to conduct a diligent search of the paper-based and electronically-maintained documents in the possession, custody or control of \_\_\_\_\_ in response to the Summons. When conducting the search of the electronically-maintained documents, \_\_\_\_\_ used the following key words:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.
4. The process of document production was conducted as directed and I am fully satisfied that all documents requested by the Commission, as referenced in paragraph 2 above, have been produced to the Commission.

**THE ELLIOT LAKE  
COMMISSION OF INQUIRY**

The Honourable Paul R. Bélanger,  
Commissioner

**LA COMMISSION  
D'ENQUETE ELLIOT LAKE**

L'honorable Paul R. Bélanger,  
Commissaire

5. If I learn, before the public release of the Commissioner's final report that this Certification was based on incorrect information, the Commission shall be contacted forthwith with the correct information.

Date: \_\_\_\_\_

\_\_\_\_\_  
Name

1400 Blair Place, 6<sup>th</sup> Floor  
Ottawa, Ontario K1J 9B8

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## Appendix Q – Example of Section 17 Notice

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger  
Commissaire

#### BY EMAIL

#### CONFIDENTIAL

I am writing to you in your capacity as counsel to \_\_\_\_\_. The purpose of this letter is to provide notice of the potential for a finding of misconduct against your client. This letter is confidential; it will not be made public in any way by the Commission.

This Commission is prohibited by its Order in Council, and by the governing jurisprudence, from expressing any conclusion or recommendations regarding the potential civil or criminal liability of any person or organization. The Commission is however, required to find the facts in respect of the matters it is directed to inquire into.

One of the guiding principles of this Commission is that it will ensure procedural fairness to those persons who may be affected by its activities. We are well aware that, as Justice Cory noted in *Canada (Attorney General) vs. Canada (Commission of Inquiry on the Blood System in Canada – Krever Commission)*, [1997] S.C.R. 440, findings of misconduct (which he defined as including “improper or unprofessional behavior” or “bad management”) should not be the principal focus of this public inquiry. They should only be made in those circumstances where they are required to carry out the inquiry’s mandate. Nevertheless, it may well be necessary for us to make findings of misconduct. As Justice Cory wrote:

The findings of fact and the conclusions of the Commissioner may well have an adverse effect upon a witness or a party to the inquiry. Yet they must be made in order to define the nature of the responsibility for the tragedy under investigation and to make the helpful suggestions needed to rectify the problem... procedural fairness is essential for the findings of Commissions may damage the reputation of a witness. For most, a good reputation is their most highly prized attribute. It follows that it is essential that procedural fairness be demonstrated in the hearings of the Commission.

Section 17 of the *Public Inquiries Act, 2009*, is a statutory enactment of that requirement of procedural fairness. It provides that a Commission shall not find misconduct by a person unless reasonable notice of the possible finding and the summary of the evidence supporting the possible finding have been given to that person, and the person has been given a reasonable opportunity to respond.

Neither the statute nor the jurisprudence has set out the standard to be applied when determining whether a notice ought to be issued. In our view, the appropriate standard, keeping in mind our fairness obligation, is whether there is evidence which, if accepted,

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and in the absence of an explanation, could be the basis for a finding by the Commission that the person had mismanaged matters relating to the structural integrity of the mall.

As Justice Cory noted, the timing of notices will always depend upon the circumstances. Your client has not applied to become a participant in this Commission of Inquiry. As a result, we have closely scrutinized the documents collected to date which may well become evidence in the inquiry. The purpose of that scrutiny was to ensure that, if there was the potential for a finding of misconduct against your client, a notice be issued now so that your client is provided with an opportunity to take part in the inquiry in order to protect his/her reputation.

It appears that facts set out in documents obtained by the Commission and evidence obtained during the Hearing could, if accepted, and in the absence of an explanation, be the basis for a finding that

The evidence which could support these potential findings is found in

The more significant documents which could support these potential findings are those set out above. In addition, the evidence disclosed in the testimony of \_\_\_\_\_ could if accepted and in the absence of an explanation, be the basis for such findings. There may be other evidence which could support these potential findings.

I want to make it very clear that by providing this notice to your client now, we are not indicating that we have reached any conclusions whatsoever as to the underlying facts giving rise to the collapse of the mall. Much of the evidence has yet to be called. The purpose of this notice is simply to ensure that we are fair to your client so that, if the Commissioner comes to the conclusion that the evidence requires him to make a finding of misconduct against your client, he will be satisfied that procedural fairness was accorded.

Yours very truly,

Commission Counsel

## Appendix R – Letter to Attorney General requesting extension

### THE ELLIOT LAKE COMMISSION OF INQUIRY

The Honourable Paul R. Bélanger,  
Commissioner



### LA COMMISSION D'ENQUÊTE ELLIOT LAKE

L'honorable Paul R. Bélanger,  
Commissaire

#### **Delivered by Courier**

November 7, 2013

The Hon. John Gerretsen  
Ministry of the Attorney General  
720 Bay Street, 11th Floor  
Toronto, Ontario M5G 2K1

#### **Re: Elliot Lake Commission of Inquiry**

Dear Mr. Attorney,

The purpose of this letter is to seek an amendment to the Order-In-Council creating the Elliot Lake Commission of Inquiry to extend the time for delivery of its final report.

You will recall that the Order-in-Council was dated 19 July 2012.

Section 12 provides that: "The Commission shall endeavour to deliver a final report containing its findings, conclusions and recommendations to the Attorney General within 12 months, but in any event no later than 18 months, after the commencement of the inquiry."

Section 14 provides that "The Commission shall be responsible for translation and printing and shall ensure that the final report is delivered in both English and French in electronic and printed versions and available in sufficient quantities for public release."

Consequently, a final report is due no later than 19 January 2014.

It is now apparent to me, after consultation with my Commission Counsel and staff, that it will be impossible to meet that deadline.

I therefore seek an extension until 31 October 2014. The comments that follow explain the reasons for my request.

As you are aware, there are three distinct aspects to my mandate –

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- 1) Inquire into the events surrounding the collapse of the Algo Centre Mall in Elliot Lake on June 23, 2012;
- 2) Inquire into the emergency management and response subsequent to the collapse; and
- 3) Review the existing legislation, regulations, by laws, policies, processes and procedures relating to the first two subjects of the inquiry;

I begin by noting that at the time of my appointment as commissioner, a principled determination of the time required for the Commission to carry out its mandate would have been impossible. It was only after the initial investigative stage, which lasted until February of 2013, that Commission Counsel and I developed a meaningful grasp and understanding of the magnitude of the problem we were tasked to analyze. It was only then that we were able to fix a tentative schedule for the hearings that eventually required hearing the evidence of 118 witnesses.

That investigative stage could only begin after Commission Counsel and staff were recruited and after temporary premises in Ottawa were found and equipped. Indeed our offices and infrastructure were only up and running in late September of 2012, in part because of the difficulty of locating suitable space. Our investigation was a cumulative and progressive process involving the issue and service of well over 100 summons and the collection, coding and analysis of many thousands of responding documents, interviewing of witnesses, preparation of documents briefs and will-say statements for each witness. The breadth of that endeavour, particularly in relation to the events preceding the Algo Mall collapse, was due to the age of the Mall itself. Our research spanned over 30 years, commencing with its concept and construction in 1979 and involved the interplay of a great number of players, ranging from architects, engineers, contractors and owners to municipal and provincial officials, lenders and tenants. This was because the narrative of the collapse was truly a thirty year story.

Investigation of the emergency response to the collapse also involved many individuals and organizations.

Unfortunately, as I have written to you previously, response to Commission summonses was not always timely. By way of example, as late as September of 2013, when hearings were nearly complete, the O.P.P. delivered some 6,500 further documents to the Commission. As a matter of prudence and diligence, these had to be sorted for relevance and analyzed.

By way of further example, on the 13th of December of 2012, Commission Counsel wrote to Ms. Malliha Wilson, Assistant Deputy Attorney-General, pointing out that approximately 100,000 documents that were still being reviewed prior to production by agencies and Ministries of Government had yet to be provided; 40,000 documents in the possession of the City of Elliot Lake were still to be produced.

Late production of documents was a recurring reality throughout the hearing phase. In one instance, proceedings had to be initiated before the Divisional Court to compel production.

During this initial stage of our work, hearings had to be conducted to determine who would be granted standing to participate in the Inquiry and to make recommendations to you on which should receive funding. There was also a contested confidentiality hearing in Ottawa. Suitable premises for the hearings in Elliot Lake had to be found and equipped, as well as more permanent quarters for the Commission in Ottawa.

I omit a recitation of the myriad of other details that preceded the commencement of hearings. Of necessity, the distance and relative remoteness of the City of Elliot Lake was a complicating factor in almost everything we did, from interviewing witnesses to transporting materials to finding available suitable accommodations.

The hearing phase of the Commission began immediately after construction of the hearing room in Elliot Lake and appurtenant spaces was complete, in early March of 2013. With the exception of a three-week break in late June and early July, hearings were held four days a week without interruption until October 9th. Our hearing day began at 9 a.m. and ended at 5 p.m. I arranged for a four-day weekend every second week to allow Counsel and staff to return to Ottawa to attend to business and personal concerns. The sacrifice my staff showed in living apart from their families for such a long period of time was truly remarkable.

I am returning to Elliot Lake on November 12th to hear oral submissions relating to the second part of the hearings (the emergency response). We will have then sat 126 days and examined 118 witnesses.

At the time of writing this letter to you, 6 expert roundtables are scheduled in Ottawa for November 18th to November 21st inclusively as well as December 5th and 6th. These roundtables, which will be moderated by my Senior Counsel, will assist me in formulating realistic recommendations in my Report.

My plan is to issue a two-part report – one on the events leading to the collapse of the Algo Centre Mall and a second on the emergency response to it.

My estimation of further time requirements is as follows:

At the present time, Associate Counsel are working on the condensing and analysis of all of the evidence, an exercise which involves a review of close to 30,000 pages of transcript. Following several discussions on the progress of that exercise, I have determined that this process will take until December 31st, 2013 for Part I of the Inquiry and until March 31st 2014 for Part II. My Senior Counsel are currently engaged in preparation for the Roundtables, including written submissions and background material and other pertinent tasks. Commencing on January 1st 2014, they will assist me in the delivery of Part I of the report. I project that stage will be complete by March 31st, 2014

and that much of that work will be ready for editing, translation and layout. Translation may be made more difficult than usual owing to the technical nature of much of the evidence. The analytical and writing portion relating to Part II, as well as the drafting of overall conclusions, recommendations and executive summaries will commence on April 1st 2014 and take us to approximately June 30th to complete. I then estimate that editing, translation and layout will take a further three months, so that the Report in its approximate final form should be ready for final review and printing on the 30th of September, 2014. I then allow for a further 30 days to complete printing and to allow for unforeseen circumstances and delays, in order to confidently say to you that the report will be ready for distribution by October 31st, 2014.

I anticipate that even with an extension to this date, the Commission will remain within its allocated budget envelope.

I recognize, Mr. Attorney, that this request extends the Commission some 9 and ½ months beyond its original mandate.

I can assure you, however, that the delay is due exclusively to the volume of work that has faced the Commission; all of its members have attended to this duty with single minded purpose, energy, devotion and commitment. The extension, as explained above, is absolutely essential if the Commission is to meet its mandated objectives and to provide a full and comprehensive report to the Government and the people of Elliot Lake and indeed all of Ontario.

I would be pleased to provide you with any additional information as required.

At the same time, may I request that the increase in Counsel's salary cap be maintained beyond the 15th of December 2013. My understanding was that it had only been extended to that date in anticipation of this extension request.

Yours very truly,

Paul R. Bélanger  
Commissioner

PRB/mab



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Glossary,  
Abbreviations  
and Acronyms



## Glossary, Abbreviations and Acronyms

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## Glossary

<b>accountability</b>	a sign-in / sign-out system used by emergency responders to track each responder's location at any given time.
<b>The Collins Hall</b>	a City-owned facility in Elliot Lake close to the Mall which was designated as a place for family members of victims or possible victims and other members of the community to gather, both to await news and to benefit from support services.
<b>commissioner for community safety</b>	senior position within the Ministry of Community Safety and Correctional Services. The fire marshal and the chief of Emergency Management Ontario both report to this person.
<b>Community Control Group (CCG)</b>	the emergency control group, composed of officials or employees of each municipality including the mayor, the chief administrative officer, and the fire chief, which convenes when an emergency occurs to support the incident commander and look after the well-being of the community. It activates the municipality's emergency plan and also supports the responders.
<b>crush syndrome</b>	a condition sometimes caused when parts of the body are crushed after a structural collapse, causing muscle breakdown and the release of potentially toxic muscle cell components and electrolytes into the circulatory system. Once released, the victim can go into shock, leading potentially to lethal cardiac arrhythmias and kidney failure. The condition is treatable.
<b>declaration of emergency</b>	a signed declaration in writing made by the head of council (the mayor) which indicates that the situation exceeds the scope of the local emergency response. Once received at the Provincial Emergency Response Centre, this declaration can lead to the deployment of emergency response teams such as HUSAR/TF3 and UCRT.
<b>Emergency Management Ontario (EMO)</b>	the branch of the Ministry of Community Safety and Correctional Services responsible for developing, promoting, implementing, and maintaining emergency management programs in the province. In addition, it maintains the Provincial Emergency Response Plan.
<b>Emergency Operations Centre (EOC)</b>	a designated and properly equipped facility from which the Community Control Group manages the emergency.
<b>Emergency Preparedness and Response Unit of the Ontario Fire Marshal</b>	During an emergency, the operations manager is on call 24 hours a day to assess needs, act as a liaison between provincial resources and local responders, and, through the Provincial Emergency Operations Centre, deploy emergency teams such as HUSAR/TF3 and UCRT.
<b>emergency response plan</b>	a plan developed and maintained to direct the response to an emergency. Emergency Management Ontario has developed a template for use by municipalities such as Elliot Lake.
<b>Emergency Response Team</b>	the OPP unit that deals with such elements as evidence searches and ground search and rescue.
<b>graduated problem solving</b>	the emergency response system in Ontario begins at the local level and expands when needed to involve responders from neighbouring communities, from the provincial government, and from the federal government.



<b>hollow core slabs</b>	a precast concrete slab containing pre-stressed cables, typically used in the construction of floors in multi-storey buildings. The precast concrete slab has tubular voids extending the full length of the slab, usually with a diameter equal to two-thirds to three-quarters of the slab thickness, thus making the slab much lighter than a solid floor slab of equal thickness or strength.
<b>hot zone</b>	the collapsed area within the Mall, including the fallen steel beam, the dislodged escalators, the hanging concrete slabs, and the rubble pile of concrete, wires, and glass under which the victims were thought to be located.
<b>HUSAR/TF3</b>	the term used in this Report for the Heavy Urban Search and Rescue team operated by the City of Toronto and known variously as Toronto HUSAR, Canada Task Force 3, and TF3. It is multi-service, multi-skilled, and multi-functional, and its primary purpose is to rescue persons trapped in collapsed structures. It is staffed by members of Toronto Police Service (the search component, including a canine unit) and Toronto Fire Service (the rescue component), paramedics from Toronto Emergency Medical Services and doctors from Sunnybrook Centre for Prehospital Medicine (the medical component), structural engineers from Stephenson Engineering, and occasionally drivers from Toronto Water. When deployed as a provincial asset, the province assumes the cost of both salaries and expenses for the duration of the deployment.
<b>incident action plan</b>	a written or oral plan, approved by the incident commander, which sets out the general objectives and overall strategy for managing the emergency response.
<b>incident commander</b>	according to the Incident Management System, the individual with overall authority for conducting the response, managing operations at the site of the emergency, and deciding when the rescue operation transitions into a recovery operation.
<b>Incident Management System (IMS)</b>	a standardized province-wide approach to emergency management within a common organizational structure and encompassing personnel, facilities, equipment, procedures, and communications. Under this plan, the incident commander has overall authority to conduct the emergency response operation, and all responders from the different jurisdictions and organizations work together toward a common goal.
<b>laced-post shore</b>	a form of shoring used to support heavy weights in which two vertical posts are laced together with cross bracing. To act efficiently, the shore must be positioned so that the load is directly over the vertical members.
<b>LifeLocator</b>	a sensitive portable device that can detect faint signs of breathing and movement under a collapsed structure. To operate correctly, it requires an exclusion zone where no other humans are present.
<b>Millennium Crane</b>	a privately owned company in Sault Ste. Marie whose 60-tonne and 165-tonne cranes removed the hanging steel beam and several concrete slabs from the collapse zone area.
<b>Ministry of Community Safety and Correctional Services (MCSCS)</b>	the ministry with the major responsibility for emergency response in Ontario, including Emergency Management Ontario, the Office of the Fire Marshal, and the commissioner for community safety.
<b>Ministry of Labour (MOL)</b>	the ministry charged with enforcing the <i>Occupational Health and Safety Act</i> . It typically investigates all cases of serious injury or fatalities that occur at a workplace.

<b>Office of the Fire Marshal</b>	a major provincial-level actor, along with the Ontario Provincial Police and Emergency Management Ontario, in monitoring or responding to an emergency at the local level.
<b>personal accountability report (PAR)</b>	a system designed to allow for the tracking of those responders actually in the hot zone. Responders are logged in and out of the hot zone. While inside, they are required to identify their location.
<b>pile</b>	the rubble pile under which the victims in the collapse zone at the Mall were thought to be located.
<b>Priestly Demolition</b>	a privately owned company in Toronto. Three of its large machines were transported to Elliot Lake: the Komatsu 850, a high-reach crane with an articulated arm that allowed it to extend out and down, and with attachments that could grab, crush, cut, and pile materials gently; the Komatsu 490, a standard excavator with a grapple; and the Link Belt 460, with a sheer attachment that could cut through thick steel.
<b>Provincial Emergency Operations Centre (PEOC)</b>	A fully equipped facility, managed by Emergency Management Ontario and located within the Ministry of Community Safety and Correctional Services, which serves as the initial point of contact for municipalities. It is staffed at all times to receive declarations of emergencies and to notify the emergency management coordinators of the various ministries.
<b>recovery operation</b>	the phase of a search operation when there is no hope that the victim will be found alive and the objective is to recover the body with dignity. Workers do not risk their own safety at the scene, and cadaver dogs rather than “live” dogs are used in the search. Some of the recovery tasks may be done by mechanical equipment such as cranes.
<b>rescue operation</b>	the phase of a search operation when there is hope that the victim will be found alive. Rescue workers perform their jobs with care not to endanger the victim and are expected to take an element of risk for their own safety. “Live” dogs rather than cadaver dogs are used in the search.
<b>rigging</b>	a method of removing heavy objects by wrapping and securing them with ropes, cables, and slings and hoisting them by crane from the construction or the emergency site.
<b>search dogs</b>	highly trained dogs that work with their handlers to assist in finding victims after a building collapse or other calamity. Most dogs now are trained to be either “live” dogs or cadaver dogs. The “live” dogs are trained to bark and show active commitment to the victims they find, such as by circling in the specific location or inserting their heads into a void. The cadaver dogs, in contrast, give a passive indication by sitting or lying down on the spot and not barking.
<b>site commander</b>	the HUSAR/TF3 officer in charge of the team at the emergency site.
<b>sewer camera</b>	a camera equipped with a light and located at the end of a long hose that can be used as a search tool in voids and probe holes within a collapse zone.
<b>shoring</b>	the process of supporting a structure in order to prevent collapse. Different forms of shoring are used, depending on the particular circumstances – e.g., laced-post shores and T-spot shores.
<b>spotters</b>	individuals who are trained to look for something. In a disaster zone, they are placed on the periphery to watch out for hazards and to alert the workers at the site.

- thermal camera** a device that forms an image using infrared radiation. Firefighters sometimes employ it to help find people at an emergency site.
- T-spot shore** a quick, temporary shore built in the shape of a T and centred directly under the load it is intended to support. It is used while workers built a more secure system such as laced-post shores.
- tunnelling** a loose term that means simply moving forward toward the objective, not actually building a tunnel.
- UCRT** the team operated by the Ontario Provincial Police which originated as the Provincial Emergency Response Team. It has two elements – Urban Search and Rescue (USAR) and Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE) – and includes two canine handlers and five advanced-care paramedic specialists.
- void** a cavity in a pile of concrete slabs and rubble that potentially shelters a victim fully or partially. It also enables rescue workers to look for clues in the pile or to insert cameras and other equipment in their search for trapped persons.
- “widow-maker”** a term used to describe large slabs of concrete, steel beams, and glass that are hanging precariously after a structural collapse.



## Abbreviations and Acronyms

ALS	advanced life support
Capt.	captain
CBRNE	chemical, biological, radiological, nuclear, and explosive
CCG	Community Control Group
CEMC	community emergency management coordinator
Cmdr.	commander
COG	continuity of government
CONOPS	concept of operations
COOP	continuity of operations
CRT	critical response team
CSA	Canadian Standards Association
Cst.	constable
Det.	detective
Det Sgt.	detective sergeant
ECG	emergency control group
EIC	emergency information centre
EIO	emergency information officer
EL	Elliot Lake
ELMAC	Elliot Lake Mall Action Committee
ELNOS	Elliot Lake and North Shore Corporation for Business Development
EMAC	Emergency Management Assistance Compact
EMCPA	Emergency Management and Civil Protection Act
EMD	emergency medical dispatch
EMO	Emergency Management Ontario
EMPC	Emergency Management Program Committee
EMS	Emergency Medical Services
EMU	Emergency Management Unit
EOC	Emergency Operations Centre
EPRU	Emergency Preparedness and Response Unit

EPSD	Emergency Planning and Strategic Development
ERP	emergency response plan
ERT	emergency response team
FAC	finance & administration chief
FC	fire chief
FD	Fire Department
FEMA	Federal Emergency Management Agency
FOG	Field Operations Guide
GPS	global positioning system
GSSI	Geographical Survey Systems Inc.
HAZMAT	hazardous material
HQ	headquarters
HUSAR	Heavy Urban Search and Rescue
IAEM	International Association of Emergency Managers
IAFC	International Association of Fire Chiefs
IAFF	International Association of Fire Fighters
IAP	incident action plan
IC	incident command / incident commander
ICP	incident command post
ICS	incident command system
IMAT	incident management assistance team
IMS	Incident Management System
IMT	incident management team
Insp.	inspector
ITC	Incident Telecommunications Centre
JEPP	Joint Emergency Preparedness Program
JEIC	Joint Emergency Information Centre
JIC	Joint Information Centre
JOC	Joint Operations Centre
LEOP	Local Emergency Operations Plan
LO	liaison officer
LS	Logistics Section
LSC	logistics section chief

<b>MAG</b>	Ministry Action Group
<b>MAH</b>	Ministry of Municipal Affairs and Housing
<b>MBO</b>	management by objective
<b>MCSCS</b>	Ministry of Community Safety and Correctional Services
<b>MOL</b>	Ministry of Labour
<b>NCO</b>	non-commissioned officer
<b>NER</b>	north east region
<b>NFPA</b>	National Fire Protection Association
<b>NGO</b>	non-governmental organization
<b>NIMS</b>	National Incident Management System
<b>NRCC</b>	National Response Coordination Centre
<b>NRP</b>	National Response Plan
<b>OAFC</b>	Ontario Association of Fire Chiefs
<b>OBOA</b>	Ontario Building Officials Association
<b>OFM</b>	Office of the Fire Marshal
<b>OFMEM</b>	Office of the Fire Marshal and Emergency Management
<b>OHSA</b>	Occupational Health and Safety Act
<b>OMR</b>	Ontario Mine Rescue
<b>OPFFA</b>	Ontario Professional Fire Fighters Association
<b>OPP</b>	Ontario Provincial Police
<b>OPS</b>	operations
<b>OS</b>	operations section
<b>OSC</b>	operations section chief
<b>PAR</b>	personal accountability report
<b>PEOC</b>	Provincial Emergency Operations Centre
<b>PERT</b>	Provincial Emergency Response Team
<b>PIO</b>	public information officer
<b>POC</b>	Provincial Operations Centre
<b>PS</b>	Planning Section
<b>PSC</b>	planning section chief
<b>RSO</b>	Revised Statutes of Ontario
<b>SAGE</b>	Seniors' Action Group of Elliot Lake

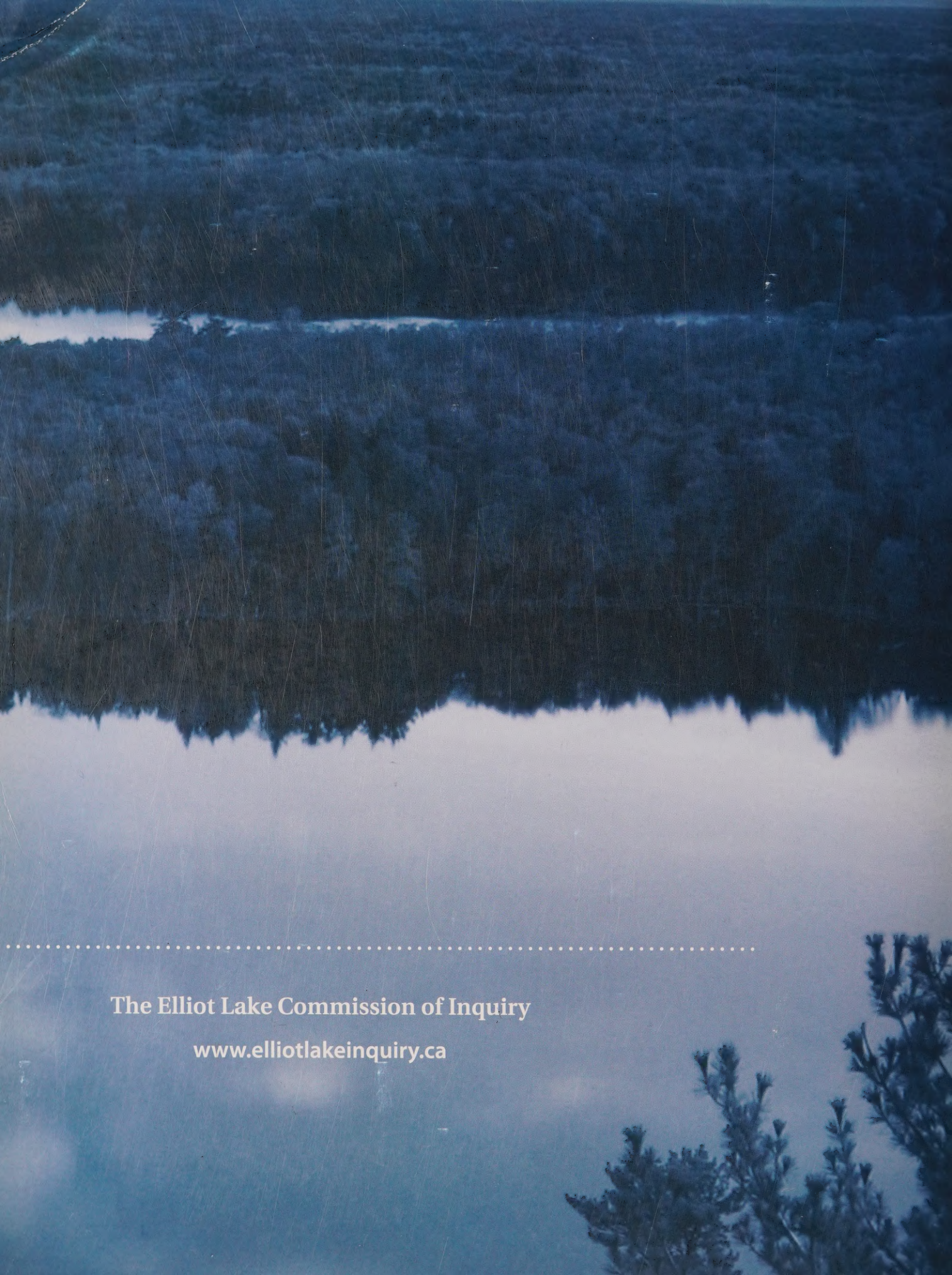


SCR	Supreme Court Reports
SITREP	situation report
SO	safety officer
SO	Statutes of Ontario
SOP	standard operating procedure
Supt.	superintendent
SUV	sport utility vehicle
TBD	to be determined
TEEX	Texas A&M Engineering Extension Service
TF3	Task Force 3
TPS	Toronto Police Service
UAC	Unified Area Command
UC	Unified Command
UCRT	USAR and CBRNE Response Team
USAR	urban search and rescue
WMD	weapons of mass destruction



PHOTO: Peter Rehak





The Elliot Lake Commission of Inquiry

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